



**IHS RPMS  
PCC Management Reports  
(APCL)  
Version 3.0**

**User's Manual**

**February 1997**

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# Preface

The richness of the Patient Care Component (PCC) database, as well as the functional need for retrieving data in an organized manner for administrative and clinical management purposes, led to the development of the PCC Management Reports module. The options available in this module allow users to quickly and easily generate reports containing the data they need from the PCC.

The PCC Management Reports module, version 3.0, provides numerous reports for patient and program management. This module facilitates the retrieval of data from the PCC by offering the user predefined report options as well as tools for custom-report generation. Users specify the parameters for each of the reports in order to retrieve the data of interest. Reports are organized by category on the main menu for ease of use.

This manual has been written for Resource and Patient Management System (RPMS) users who will utilize the PCC Management Reports module and other data retrieval tools for clinical and administrative functions. Separate installation and technical manuals for this module are available for Information Resources Management (IRM) personnel who are responsible for installing and maintaining this module.

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# PCC Management Reports

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## **Introduction**

The PCC Management Reports Module provides numerous reports for patient and program management. Access to the PCC Management Reports menus is restricted to authorized individuals and is controlled by the facility local Site Manager through the use of locks (code words assigned to the user that allow access to a menu).

This manual provides detailed information on the use of the PCC Management Reports menus. All users should take the time to read through this guide prior to using PCC Management Reports. This manual contains special information about the report options available and includes a sample of each report.

Many of these reports may be printed instantaneously; however, some will take a considerable amount of time to generate. Notes on run time are included for reports that require longer processing times. These printouts can be queued to specific devices (see *Queuing Output*, page 4) so that printing can occur after regular business hours.

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## PCC Management Reports Menu

The PCC Management Reports menu, shown below, consists of several categories of reports from various PCC files. Each menu option represents a sub-menu that contains a number of reports within that category. Note that any menu option followed by an ellipses ( . . . ) contains a sub-menu.

```
*****
**   PCC Management Reports   **
*****
                          Version 3.0

                          SELLS HOSPITAL/CLINIC

PLST  Patient Listings ...
RES   Resource Allocation/Workload Reports ...
INPT  Inpatient Reports ...
QA    Quality Assurance Reports ...
DM    Diabetes Program QA Audit ...
APC   APC Reports ...
PCCV  PCC Ambulatory Visit Reports ...
BILL  Billing Reports ...
BMI   Body Mass Index Reports ...
ACT   Activity Reports by Discipline Group ...
CNTS  Dx & Procedure Count Summary Reports ...
IMM   Immunization Reports ...
DR    PCC Patient Data Retrieval Utility
RT    Report Template Utility ...
STS   Search Template System ...
QMAN  Q-Man (PCC Query Utility)
FM    FileMan (General) ...
```

Extended help is available for most of the options. To access a help screen, type a question mark and the label for the menu option for which you require help; for example, typing "?PLST" generates a description of the Patient Listings option.

The following sections of this manual provide detailed information for each of the report categories shown above. The categories are presented in the order in which they appear on the report menu. A brief description of each sub-menu screen (for example, Patient Listings) is provided, followed by examples and descriptions of each report contained in that sub-menu.

## Queuing Output

It is important that you do not run reports or retrievals requiring lengthy processing time during normal working hours, unless you are operating an upgraded RISC 6000 CPU or are at a very small facility. Jobs that require lengthy processing times should be queued to run after business hours or on weekends. Throughout this manual, notations indicate which reports may have lengthy processing times. Please contact your local Site Manager if you have questions regarding report queuing.

To queue a job, enter "Q" at the DEVICE prompt and press return. Then enter an appropriate device number and press return. Answer the question about when to print by entering an after-hours date and time, such as "T@6PM" to have the job processed Today at 6:00 p.m.



## PLST Patient Listings

This set of reports allows you to list groups of patients. The reports include patient listings by Date of Birth, Current Community, Date of Death, Sex, Eligibility, Classification/Beneficiary, and Tribe of Membership. In most cases, the report includes the Patient's Name, Chart Number, and Date of Birth.

```
*****
**   PCC Management Reports   **
**   Patient Listings        **
*****
Version 3.0

SELLS HOSPITAL/CLINIC

Please remember to queue ...
(*) denotes that the report is instantaneous

CRC   Living Patients by Community of Residence (*)
DOB   Living Patients by Date of Birth (*)
DEM   Living Patients by Multiple Demographic Variables
DOD   Deceased Patients by Date of Death (*)
PGEN  Patient General Retrieval
DP    Patient Listing by Primary Care Provider
VDP   Patients by Primary Care Provider w/ Visit Counts
DMG   Detailed Patient Register R-DMG-510
```

## CRC Living Patients by Community of Residence (\*)

This report displays a list of living patients by Community, along with their Dates of Birth, Sex, and Tribes of Membership.

You will be asked to enter one particular community or all communities. The total number of patients per community and the total of all the requested communities' populations will be displayed. To shorten the report generation time, request only a narrow range of communities.

---

ACHI PATIENTS				JAN 25, 1995 15:10	PAGE 1
NAME	DATE OF BIRTH	SEX	TRIBE OF MEMBERSHIP		
-----					
CURRENT COMMUNITY: ACHI					
MARTIN, MARY	JAN 1, 1925	FEMALE	TOHONO	O'ODHAM	NATIO
SMITH, BILL	MAY 1, 1948	MALE	TOHONO	O'ODHAM	NATIO
WHITE, THERESA	JAN 1, 1939	FEMALE	TOHONO	O'ODHAM	NATIO
PETERS, DAVID	1890	MALE	TOHONO	O'ODHAM	NATIO
MILLER, BILL	MAR 1, 1962	MALE	TOHONO	O'ODHAM	NATIO
JONES, LISA	APR 1, 1963	FEMALE	TOHONO	O'ODHAM	NATIO
MARTIN, IRMA	JUN 1, 1964	FEMALE	TOHONO	O'ODHAM	NATIO
PETERS, BILL	MAR 1, 1964	MALE	PIMA		
BROWN, SAM	MAR 1, 1928	MALE	NON-INDIAN	BENEFICIA	
PETERS, JOHN	NOV 1, 1966	MALE	TOHONO	O'ODHAM	NATIO
BROWN, SAM	OCT 1, 1967	MALE	TOHONO	O'ODHAM	NATIO
GREEN, LARRY	DEC 1, 1958	MALE	TOHONO	O'ODHAM	NATIO
GREEN, THERESA	JUN 1, 1920	FEMALE	TOHONO	O'ODHAM	NATIO
BROWN, DENNIS	APR 1, 1940	MALE	TOHONO	O'ODHAM	NATIO
-----					
SUBCOUNT 14					

---

---

**DOB Living Patients by Date of Birth (\*)**

The DOB report displays a list of all living patients by Date of Birth. You will be asked to enter a date range from the earliest to latest date of birth. You may sort the list by Patient Name or Date of Birth. The report will include the Patient's Name, Date of Birth, and Chart Number. The total number of patients on the list will be displayed at the end of the report.

---

PATIENT LISTING BY DATE OF BIRTH		JAN 26,1995	14:06	PAGE 1
NAME	DOB	CHART #		
MILLER, SARAH	JAN 1,1944	77467		
MARTIN, MARTIN	JAN 1,1944	99009		
PETERS, THERESA	FEB 1,1944	98775		
MARTIN, JIM	FEB 1,1944	31382		
WHITAKER, GEORGIE WAKEFIELD	FEB 22,1944	53466		
MARTIN, JAMES	MAR 5,1944	90774		
RILEY, SUSIE	APR 8,1944	14495		
GREEN, DARLENE	MAY 1,1944	21087		
SALADIN, SALLY ANN	MAY 14,1944	23545		
WHITE, THERESA	JUN 1,1944	94867		
JOHNSON, DIANE	JUL 1,1944	29574		
COUNT	11			

---

---

## DEM    Living Patients by Multiple Demographic Variables

This report option allows you to display a list of patients by selected demographic variables. In each report, the Patient's Name, Date of Birth, Tribe of Membership, and Current Community is printed. You will be able to select the sort variables for the report. The sort variables you may choose from are: Date of Birth, Sex, Current Community, Tribe of Membership, Classification/Beneficiary, Eligibility, and Patient Name.

The sample report below lists patients by community and date of birth.

---

PATIENT LISTING BY COMMUNITY AND BIRTHDATE	JAN 26, 1995	14:09	PAGE 1
NAME	DOB	TRIBE OF MEMBERSHIP	COMMUNITY
-----			
MILLER, LISA	08/01/35	TOHONO O'ODHAM NATIO	SELLS
MILLER, TANYA	08/15/35	TOHONO O'ODHAM NATIO	SELLS
PEREZ, LILY	08/11/36	TOHONO O'ODHAM NATIO	SELLS
RILEY, SUSIE	04/08/44	TOHONO O'ODHAM NATIO	SELLS
SAVAGE, ANDREW	01/01/47	TOHONO O'ODHAM NATIO	SELLS
GARCIA, JOE FRANK	06/25/50	TOHONO O'ODHAM NATIO	SELLS
GOETTERT, JUDY	10/31/52	NON-INDIAN BENEFICIA	SELLS
NORTON, JERRY F	01/01/57	TOHONO O'ODHAM NATIO	SELLS
NEZ, LARRY	04/17/59	NAVAJO TRIBE OF AZ,	SELLS
PEREAU, KAREN JEAN	03/04/63	DAKOTA (SIOUX)	SELLS
RIVERS, CAMERON ANTHONY	07/22/63	GILA RIVER PIMA MARI	SELLS
HALL, JULIE PATRICIA	08/30/65	NON-INDIAN BENEFICIA	SELLS
SMITH, BOB	01/01/77	NON-INDIAN BENEFICIA	SELLS
-----			
SUBCOUNT	13		

---

**Estimated Run Time:** For facilities with numerous patient files, this report may take a long time to run unless the first sort variable selected is a specific Current Community. If you have selected a specific community, the run time for the report will be a function of the size of that community and the number of other variables chosen for sorting. For example, a report sorting first by a small Community and then by Date of Birth would run quickly. A report sorting first by a large Community (over 1,000 patients) and then by Tribe and Date of Birth would take a longer time.

---

## DOD Deceased Patients by Date of Death

This report lists deceased patients by Date of Death. You will be asked to select a date range for the Date of Death. The Patient's Name, Date of Birth, Date of Death, Patient Chart Number, and Cause of Death (ICD Code) will be shown on the report. The Cause of Death will be displayed to the extent it has been entered through the ADT Inpatient or the PCC data entry process.

---

PATIENT LISTING BY DATE OF DEATH	JAN 26,1995	14:12	PAGE 1		
PATIENT NAME	DATE OF BIRTH	DATE OF DEATH	CAUSE OF DEATH		
PATIENT NAME	DATE OF BIRTH	DATE OF DEATH	CHART #		
1	PETERS, SUSAN	AUG 1,1932	JAN 1,1890	74545	571.5
2	JOHNSON, JIM	MAR 1,1962	AUG 5,1964	84755	428.0
3	MARTIN, DENNIS	JUL 1,1971	AUG 8,1975	19947	428.0
4	MARTIN, JIM	MAY 1,1967	SEP 9,1977	12575	585.
5	BROWN, JOHN	FEB 1,1978	MAR 3,1985	57866	585.
6	JOHNSON, CHARLES	MAR 1,1974	APR 4,1985	97046	585.
7	BLACK, JOHN	DEC 1,1977	AUG 8,1985	05946	585.
8	JOHNSON, JIM	APR 1,1965	SEP 5,1985	27559	428.0
9	MILLER, DIANE	MAR 1,1946	DEC 27,1985	23564	799.1
10	JONES, ANNE	JUN 1,1939	AUG 6,1986	12349	486.
11	MARTIN, BILL	JAN 1,1948	AUG 6,1986	19256	428.0
12	SMITH, SAM	JUL 1,1959	AUG 18,1986	99471	799.1
13	JONES, BILL	JAN 1,1964	NOV 20,1986	44298	486.
14	JOHNSON, LARRY	FEB 1,1980	NOV 25,1986	09683	585.

---

---

## PGEN      Patient General Retrieval

The Patient General Retrieval is a very flexible option that allows you to design your own report to list or count patients. This report option enables you to select which patients to include in the report, which data items to print, and how the data is sorted. Depending on the choices you make, you can generate a very specific report or a very general report. The logic used to produce the report may be saved for future use. You may also limit your search to predefined templates of patients that have been created with Q-Man, Case Management, or other RPMS tools.

If you design a report that is 80 characters or fewer in width, it can be displayed on your screen or printed. If your report is 81-132 characters wide, it must be printed and can only be printed on a printer capable of producing 132 character lines. Each report includes a cover page that details the user-defined criteria.

To begin generating a report using the Patient General Retrieval option, you will need to indicate whether you want to search the entire database, use a search template of patients, or transfer to Q-Man in order to create a template for use. You will select one of the following:

- S    Search Template of Patients
- P    Search All Patients
- Q    Q-Man Search

To use a search template of patients, you will be prompted for the name of the template. After entering the name of the template, you will be presented with a print item selection list. Select items to print by following the directions in the corresponding section below.

If you select to search all patients in the database, you will have the option of using report logic that you have saved from a previous report generated with PGEN. To use previously saved report logic, enter the name you assigned to the report and press return to run the report. If you are creating a new report, follow the instructions below for selecting search criteria.

Choosing Q-Man Search will transfer you to Q-Man to create a search template. (Refer to the Q-Man user manuals for specific instructions on using Q-Man.) After you have created the template, you will be returned to PGEN to select the type of report desired. Continue to create the report according to the following directions.

### Selecting Search Criteria

You will be able to select search criteria only if you choose the option for searching all patients in the database and are creating a new report. You will be presented with a referral selection menu to browse. The action items available for browsing this menu are:

- |                   |                       |
|-------------------|-----------------------|
| + Next Screen     | Q Quit Item Selection |
| - Previous Screen | R Remove Items        |
| S Select Items    | E Exit Report         |

Enter + and - at the Select Action prompt to review the selection items in the list. When you are ready to select items, press return at the prompt to accept Select Items as the default value or enter "S." You can select patients based on any combination of the data items in the list. Enter a

list or a range of numbers at the next prompt; for example, 1-4,5,20 or 10,12,20,30. You will then be prompted to define values for the items you chose, as applicable. For instance, if you selected age, you would be prompted to enter an age range.

### Patient Selection Menu

- |                        |                          |                             |
|------------------------|--------------------------|-----------------------------|
| 1) Name                | 11) Eligibility Status   | 21) EDC                     |
| 2) Sex                 | 12) Beneficiary Class    | 22) Date EDC Determined     |
| 3) Date of Birth       | 13) Cause of Death       | 23) Contraception Method    |
| 4) Age                 | 14) Medicare             | 24) EDC Determination       |
| 5) Date of Death       | 15) Medicaid             | 25) Last Menstrual Period   |
| 6) Employer of Patient | 16) Private Insurance    | 26) Service Unit of Patient |
| 7) Living Pts          | 17) Medicaid Plan Name   | 27) Problem List Dx         |
| 8) Chart Facility      | 18) Pvt Ins Plan Name    | 28) Exclude Inactive Pts    |
| 9) Community           | 19) Priv Ins Verified    | 29) Inactive Patients       |
| 10) Tribe              | 20) Desig Prim Care Prov |                             |

After you have selected and defined the patient selection criteria, you will be returned to the item list. The items that you selected will be marked with an asterisk (\*). You may add or remove items at this point, if needed, by entering “S” (select) or “R” (remove). If you are finished making your selections, press “Q” to leave this screen and continue creating your report.

### Selecting the Report Type

You will need to select the type of report to be generated from the following choices:

- T Total Count Only
- S Sub-Counts and Total Count
- C Cohort/Template Save
- D Detailed Patient Listing

Note that if you are using predefined report logic, you will **not** be presented with the Report Type menu. The report type that will print will be the same one that was saved.

The total count report prints only the total number of patients that match the selection criteria you chose. The sub-counts and total count report lists the total number of matches as well as the subtotal of each different category of the sort variable selected; for example, if you sorted the report by sex, the number of males and the number of females in the group would be printed. The cohort/template save option saves in a template the patients that match your selection criteria. Only the total number of matching patients is displayed. You can then use the template for generating reports and select the print and sort criteria that you need each time. The detailed patient listing allows you to create a report that prints only the data items that you need sorted by the variable you select. If you have selected the detailed patient listing, read the sections below for instructions on selecting the print items and sort category.

### Selecting Print Items

If you have selected the detailed patient listing report type, you will be presented with the following menu of data items that can be printed. Remember that you can print up to 132 characters if you have a printer capable of printing 132 character lines. Otherwise, your report may not exceed 80 characters. Choose the data items in the order that you would like them

printed. For instructions on browsing and selecting items, refer to the previous section "Selecting Search Criteria."

### Print Item Menu

- |                          |                             |                             |
|--------------------------|-----------------------------|-----------------------------|
| 1) Name                  | 14) Office Phone            | 26) Medicaid Plan Name      |
| 2) Chart #               | 15) Mother's Maiden Name    | 27) Pvt Ins Plan Name       |
| 3) Terminal Digit #      | 16) Next of Kin             | 28) Priv Ins Verified       |
| 4) SSN                   | 17) Community               | 29) Patient's Last Visit    |
| 5) Sex                   | 18) Tribe                   | 30) Desig Prim Care Prov    |
| 6) Date of Birth         | 19) Eligibility Status      | 31) EDC                     |
| 7) Age                   | 20) Beneficiary Class       | 32) Date EDC Determined     |
| 8) Date of Death         | 21) Cause of Death          | 33) Contraception method    |
| 9) Mlg Address-Street    | 22) Medicare                | 34) EDC Determination       |
| 10) Mlg Address-City     | 23) Medicaid                | 35) Last Menstrual Period   |
| 11) Mlg Address-Complete | 24) Private Insurance       | 36) Health Status Items     |
| 12) Home Phone           | 25) Third Party Eligibility | 37) Service Unit of Patient |
| 13) Employer of Patient  |                             |                             |

### Selecting a Sort Category

If you are creating a detailed report listing or a sub-counts and total count report, you will be presented with the following menu to select a sort variable. If you do not choose a variable, the report will be sorted by Patient Name. To select a sort variable, follow the procedures outlined in the "Selecting Search Criteria" section.

### Sort Criteria Menu

- |                        |                             |                             |
|------------------------|-----------------------------|-----------------------------|
| 1) Name                | 9) Community                | 17) Desig Prim Care Prov    |
| 2) Chart #             | 10) Tribe                   | 18) EDC                     |
| 3) Terminal Digit #    | 11) Eligibility Status      | 19) Date EDC Determined     |
| 4) Sex                 | 12) Beneficiary Class       | 20) Contraception Method    |
| 5) Date of Birth       | 13) Cause of Death          | 21) EDC Determination       |
| 6) Age                 | 14) Third Party Eligibility | 22) Last Menstrual Period   |
| 7) Date of Death       | 15) Medicaid Plan Name      | 23) Service Unit of Patient |
| 8) Employer of Patient | 16) Pvt Ins Plan Name       |                             |

### Viewing the Report

After you have specified the selection, print, and sort criteria, as applicable, you will have the option of producing a printed report or displaying the report on the screen for browsing. If you choose to browse the output on the screen, remember that your report must be 80 characters or fewer in width. Use the following keys for browsing the on-screen output:

- + next screen
- previous screen
- Q quit
- ?? more actions

If you choose to generate a printed report, your report may include up to 132 characters in width. Note that any reports greater than 80 characters wide must be printed on a printer capable of producing 132 character lines or a printer set up for condensed print.

The following sample report is based on these criteria:

### Patient Selection Criteria

Patient Age: 20-25

Patient Community: Sells

### Print Item Selection

Patient Name (1)

Patient Chart # (2)

Patient Age (7)

Patient Community (16)

Patient Tribe (17)

Patient's Last Visit (27)

TOTAL column width: 80

### Patient Sort Variable

Patient Name (1)

NAME	HRN	AGE	COMMUNI	TRIBE OF MEMBER	LAST VISIT
BURR, HUGH	SE101292	20	SELLS	TOHONO O'ODHAM	JAN 25, 1990
CARPENTER, CHESTER	SE101180	22	SELLS	TOHONO O'ODHAM	APR 04, 1994
FILMORE, ELAINE	SE102353	23	SELLS	TOHONO O'ODHAM	FEB 21, 1990
GRANT, QUENTIN	SE102356	23	SELLS	TOHONO O'ODHAM	JAN 31, 1990
GREEN, TONY	SE101002	25	SELLS	TOHONO O'ODHAM	JAN 08, 1990
HANCOCK, TAMMY	SE102500	21	SELLS	TOHONO O'ODHAM	DEC 31, 1991
JACKSON, MALLORY	SE102385	22	SELLS	TOHONO O'ODHAM	FEB 09, 1990
JONES, JODY	SE101167	23	SELLS	TOHONO O'ODHAM	JAN 10, 1990
MILLER, EDNA	SE101047	25	SELLS	TOHONO O'ODHAM	JAN 26, 1990
REAGAN, KAY	SE102966	25	SELLS	TOHONO O'ODHAM	FEB 02, 1990
ROBERTS, PENNY	SE102345	25	SELLS	TOHONO O'ODHAM	JAN 30, 1990
THATCHER, DEE	SE102838	23	SELLS	TOHONO O'ODHAM	JAN 12, 1990
VON BRAUN, BECKY	SE102840	23	SELLS	TOHONO O'ODHAM	JAN 18, 1990
WATERMAN, LENORE	SE102313	23	SELLS	TOHONO O'ODHAM	JAN 03, 1990
WINKERBEAN, JENNIFE	SE101082	24	SELLS	TOHONO O'ODHAM	JAN 29, 1990

Total Patients: 15

RUN TIME (H.M.S): 0.0.6

---

## DP Patient Listing by Primary Care Provider

This report generates a list of patients for a specific Primary Care Provider or for all Primary Care Providers at the facility.

The following sample report displays patients for all Primary Care Providers. Note that the list of patients for each provider prints on a separate page.

---

DESIGNATED PROVIDER PATIENT LISTING	APR	3,1996	10:41 AM	PAGE	1
NAME	DOB	HRN	CURRENT COMMUNITY	LAST VISIT	
DESIGNATED PROVIDER: CURTIS, CLAYTON					
WHEELWRIGHT, MANDY	JAN 1, 1970	100006	TUCSON	JAN 24, 1996	
ENOS, DON	MAR 5, 1941	100041	SANTA ROSA	FEB 07, 1996	
SMITH, JAMES A	SEP 8, 1920	123499	SELLS	JAN 25, 1996	
ADAMS, ANDY	JAN 3, 1989	101926	SELLS	DEC 20, 1994	

---

DESIGNATED PROVIDER PATIENT LISTING	APR	3,1996	10:42 AM	PAGE	2
NAME	DOB	HRN	CURRENT COMMUNITY	LAST VISIT	
DESIGNATED PROVIDER: GRAU, DAVID					
MUSTARD, CHARLES	APR 1, 1970	100999	SAN MIGUEL	SEP 28, 1994	

---

---

**VDP Patients by Primary Care Provider w/ Visit Counts**

The VDP report produces a list of patients by Primary Care Provider. It includes the patient's name, chart number, age, number of times seen by the primary care provider, number of times seen by other primary providers, and diagnoses.

The following sample report displays all designated providers for the time period from October 1, 1993 to June 30, 1994. Note that the report for each provider prints on a separate page.

Page 1

SELLS HOSPITAL/CLINIC  
 PATIENTS BY DESIGNATED PROVIDER, WITH VISIT COUNTS  
 DESIGNATED PROVIDER: CURTIS,CLAYTON  
 VISIT DATES: OCT 01, 1993 TO JUN 30, 1994

PATIENT NAME	CHART #	AGE	TIMES	OTHER	ICD DIAGNOSES
			SEEN	PROVIDERS	
			BY DP	SEEN	
WHEELWRIGHT,MAN	100006	24	0	SHORR,GREG (1)	250.00 - DM UNCOMPL/T-II/

Page 2

SELLS HOSPITAL/CLINIC  
 PATIENTS BY DESIGNATED PROVIDER, WITH VISIT COUNTS  
 DESIGNATED PROVIDER: SHORR,GREG  
 VISIT DATES: OCT 01, 1993 TO JUN 30, 1994

PATIENT NAME	CHART #	AGE	TIMES	OTHER	ICD DIAGNOSES
			SEEN	PROVIDERS	
			BY DP	SEEN	
WATERMAN,RAE JE	256	61	1	BILLARD,AB (8)	.9999 - UNCODED DIAGNOSIS
				CURTIS,CLA (17)	099.9 - VENEREAL DISEASE
				DOCTOR,JOS (1)	250.00 - DM UNCOMPL/T-II/
				ROANHORSE, (1)	293.82 - ORGANIC HALLUCIN
				SHMULE,SAM (1)	295.24 - CATATONIA-CHR/EX
					296.21 - DEPRESS PSYCHOSI
					300.9 - NEUROTIC DISORDER
	305.90 - DRUG ABUSE NEC/M				
	311. - DEPRESSIVE DISORDE				
	401.9 - HYPERTENSION NOS				
	465.9 - ACUTE URI NOS				
	719.40 - JOINT PAIN-UNSP				

RUN TIME (H.M.S): 0.0.03

---

## DMG Detailed Patient Register R-DMG-510

This report resembles the output from the R-DMG-510 report from the Albuquerque data center. For this report you will be able to select patients from a specific facility.

First, you will be asked to select a specific facility. You will then be prompted to select search criteria for a selected group of patients. Finally, you may sort the report output on a selected variable. The following selection and sort criteria are available.

### Selection Criteria

- |                   |                        |                          |
|-------------------|------------------------|--------------------------|
| 1) Name           | 8) Community           | 15) Private Insurance    |
| 2) Sex            | 9) Tribe               | 16) Medicaid Plan Name   |
| 3) Date of Birth  | 10) Eligibility Status | 17) Pvt Ins Plan Name    |
| 4) Age            | 11) Beneficiary Class  | 18) Priv Ins Verified    |
| 5) Date of Death  | 12) Cause of Death     | 19) Desig Prim Care Prov |
| 6) Living Pts     | 13) Medicare           | 20) EDC                  |
| 7) Chart Facility | 14) Medicaid           | 21) Exclude Inactive Pts |

### Sort Criteria

- |                  |                       |                          |
|------------------|-----------------------|--------------------------|
| 1) Name          | 6) Date of Death      | 11) Cause of Death       |
| 2) Chart #       | 7) Community          | 12) Medicaid Plan Name   |
| 3) Sex           | 8) Tribe              | 13) Pvt Ins Plan Name    |
| 4) Date of Birth | 9) Eligibility Status | 14) Desig Prim Care Prov |
| 5) Age           | 10) Beneficiary Class | 15) EDC                  |

---

AREA: TUCSON	INDIAN HEALTH SERVICE PATIENT REGISTRATION SYSTEM SU: SELLS	PAGE 1 DATE: 4/3/96 FACILITY: SELLS HOSPITAL/CLINIC
--------------	---	---

---

HRN	NAME	BIRTH DATE	SEX	TRB	BEN	BLOOD QUNTM	--- ELIGIBILITY ---					RESIDEN	SOC	SEC	NO	
							MCR	MCD	PVT	VET	CHS					
SEL02060	BURR, MARYLOU	1/28/90	F	282	01	1/2	X					X	SELLS	089640896		
SE102043	FARMER, MALLO	1/5/90	F	096	01	FULL		X					ANEGAM	088150881		
SE035000	SMITH, JAMIE	9/1/92	M	096	01	FULL			X		X		TUCSON	089410894		
SE102058	THATCHER, DAW	1/20/90	F	096	01	FULL			X				SELLS	047380473		

---



## RES Resource Allocation/Workload Reports

The Resource Allocation/Workload Reports provide data on the number of registered patients at a Service Unit or facility and the number of active patients, the number of visits, APC visits, and primary care provider visits by those registered patients.

This menu includes an Operations Summary sub-menu and the following report options.

```
*****
**          PCC Management Reports          **
** Resource Allocation/Workload Reports **
*****
                          Version 3.0

                          SELLS HOSPITAL/CLINIC

OPS   Operations Summary for a Service Unit or Facility ...
RPVC  Registered Patients and Visits by Community
RPVT  Registered Patients and Visits by Tribe
RPVS  Registered Pts and Visits by SU of Residence
AGE   Registered Patients by Age, Sex, Tribe, Community
ACC   Active Patient Count by Community of Residence
ACS   Active Patient Count by SU of Residence
ACT   Active Patient Count by Tribe
CH    Community Health Profile Summary
CHWL  Clinic Hourly Workload Report
```

**Estimated Run Time:** These reports may have lengthy run times depending on the parameters you specify for each one. If you need assistance determining which reports to queue, please contact you local Site Manager.

---

## OPS Operations Summary for a Service Unit or Facility

The following reports are available from the Operations Summary menu.

```
*****
**   PCC Management Reports   **
**   Operations Summary Menu **
*****
      Version 3.0

      SELLS HOSPITAL/CLINIC

OS      Generate Operations Summary
SECT    List PCC Operations Summary Sections
TYPE    Create/Edit Operations Summary Type
DISP    Display a Operations Summary Type
```

---

## OS Operations Summary

This report provides summarized data for a single month or FY-to-date for a specific facility, a selected group of facilities, or for the entire Service Unit (SU) if all data for the SU is processed on your computer.

When selecting the period for which the report is to be run, consider whether all data has been entered for that period. The summary type print choices are:

- Ambulatory Care Section Only
- CHS
- Complete Operations Summary
- In-Hospital Only
- Inpatient Only
- Pharmacy Only
- Population Only Summary

The following sample report displays a Complete Operations Summary.

---



---

OPERATIONS SUMMARY FOR MEMORIAL HOSPITAL  
FOR FY94-To-Date as of 9-30-94

Note: In parentheses (following each statistic) is the percent increase or decrease from the same time period in the previous year. "\*\*\*" indicates no data is present for one of the two time periods.

### PATIENT REGISTRATION

There are 29,275 living patients (+9%) registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There have been 1,730 new patients (+12%) registered during this time period. 317 births (-8%) and 291 deaths (+2%) occurred in this period based on data in the Patient Registration File.

### THIRD PARTY ELIGIBILITY

There were 277 patients (+7%) enrolled in Medicare Part A and 231 patients (+11%) enrolled in Part B at the end of this time period.

There were also 1,137 patients (+20%) enrolled in Medicaid and 412 patients (+36%) with an active Private Insurance policy as of that date.

CONTRACT HEALTH SERVICES

Total CHS expenditures (obligations adjusted by payments) for this period were \$564,296 (+16%). The number and dollar amount of authorizations by type were:

43 - Hospitalization	296	( +2%)	\$312,196	(+18%)
57 - Dental	351	( +8%)	\$ 80,500	( -4%)
64 - Non-Hospital Service	1,163	(+19%)	\$171,600	(+15%)

DIRECT INPATIENT

There were 1,437 discharges (+6%) during this period, accounting for 6,754 patient days (+2%). The average length of stay was 4.7 days compared to an ALOS of 4.6 during this period last year.

The five leading primary diagnoses for hospitalizations were:

1 -	Normal Delivery	104	(-15%)
2 -	Pneumonia	72	( +8%)
3 -	Diabetes Mellitus	71	(+12%)
4 -	Ischemic Heart Disease	65	(-16%)
5 -	Appendicitis	60	(+26%)

AMBULATORY CARE VISITS

There were a total of 47,291 ambulatory visits (+7%) during the period for all visit types except CHS.

They are broken down below by Type, Location, Service Category, Provider Discipline and leading Diagnoses. These do not equate to "official" APC Visits which are identified in other PCC reports.

By Type:

IHS	47,001	( +7%)
638	0	( )
Other	290	( +2%)

## By Location:

Sells Hosp.	45,800	( +9%)
San Xavier Clinic	0	( )
San Rosa Clinic	0	( )
Home	920	( -2%)
School	571	( -2%)

## By Service Category:

Ambulatory	46,601	( +7%)
Telecommunication	250	( 0%)
Not Found	440	( 0%)
Day Surgery	0	( )
Observation	0	( )
Nursing Home	0	( )

## By Clinic Type

General	46,601	( +7%)
Audiology	250	( 0%)
Well Child	440	( 0%)

## By Provider Type (Primary and Secondary Providers):

Phys	29,500	( +5%)
RN	14,200	(+19%)
LPN	11,150	( +6%)
CHN	4,111	(-14%)
Pharmacy	21,520	(+16%)
Surgeon	421	( -8%)
Internist	1,811	(-12%)
Optometrist	710	( +4%)
Podiatrist	1,111	( -2%)
Nurse Pract.	297	(-37%)
Total	84,831	(+10%)

The ten leading purposes of ambulatory visits by individual ICD Code and by APC groups are listed below. Both primary and secondary diagnoses are included in the counts.

By ICD Diagnosis

1 - Upper Respiratory Inf.	4,722 ( +8%)
2 - Prenatal Care	3,691 (-12%)
3 - Diabetes Mellitus	3,480 ( -9%)
4 - Otitis Media	3,217 (+17%)
5 - Impetigo	1,911 ( +3%)
6 - Complications of Pregnancy	1,271 ( -8%)
7 - Laceration	862 ( -8%)
8 - Sprains/Strains	490 (+11%)
9 - Rheumatoid Arthritis	487 ( +4%)
10 - Gastroenteritis	452 (-22%)

By APC Grouping

1 - URI	5,110 ( +4%)
2 - Diabetes Mellitus	3,890 (+10%)
3 - Influenza	2,001 (-10%)
4 - Impetigo	2,150 ( -4%)
5 - Prenatal Care	1,200 ( +8%)
6 - Well Child Care	1,180 (-11%)
7 - Conjunctivitis	850 (+17%)
8 - Physical Exams	710 ( -2%)
9 - Anemia	666 ( -2%)
10 - Alcoholism	652 ( +5%)

---

 INJURIES

There were 5,217 visits for injuries (-11%) reported during this period. Of these, 1,252 were new injuries (+8%). The five leading causes were:

1 - Falls	221	( +5%)
2 - Motor Vehicle	190	(-12%)
3 - Stings & Venoms	101	( -2%)
4 - Purposely Inflicted	72	(+19%)
5 - Undetermined	66	( +4%)

## EMERGENCY ROOM

There were 2,911 visits (+16%) to the ER (Clinic Code=30). Of these 1,216 had an injury diagnosis (-12%) and 621 had an alcohol-related diagnosis (+4%).

## PHARMACY

There were 21,000 new prescriptions (+17%) and 39,000 refills (+12%) during this period.

## DENTAL

There were 4,920 patients (+12%) seen for Dental Care. They accounted for 7,826 visits (+19%). The five leading service categories were:

1 - Restoration	( +8%)
2 - Extraction	(+24%)
3 - Fluoridation	(+12%)
4 - Exam	( -1%)
5 - Sealants	(+16%)

---



---

## **TYPE    Create/Edit Operations Summary Type**

This option allows you to edit an Operations Summary Type or create a new one.

Begin by entering the name of the summary type you would like to create or the name of an existing summary type to edit. Then follow the prompts to specify the components of the summary type and to indicate the order in which you want them to appear in your operations reports.

## **DISP    Display an Operations Summary Type**

This option allows you to display an Operations Summary Type. The components of each are shown together with the order in which they will appear in a report.

You may choose from the list below or select a summary type that you have created.

- Ambulatory Care Section Only
- CHS
- Complete Operations Summary
- In-Hospital Only
- Inpatient Only
- Pharmacy Only
- Population Only Summary

The following sample shows the Complete Operations Summary type.

---



---

PCC MAN REPORTS OP SUM TYPE LIST

APR 11,1996 16:12

PAGE 1

---

NAME: COMPLETE OPERATIONS SUMMARY

SUMMARY ORDER: 1

SUMMARY ORDER: 2

SUMMARY ORDER: 3

SUMMARY ORDER: 4

SUMMARY ORDER: 5

SUMMARY ORDER: 6

COMPONENT NAME: POPULATION/THIRD PARTY

COMPONENT NAME: CONTRACT HEALTH SERVICES

COMPONENT NAME: INPATIENT SERVICES

COMPONENT NAME: AMBULATORY

COMPONENT NAME: IN-HOSPITAL

COMPONENT NAME: PHARMACY

---

**RPVC Registered Patients and Visits by Community**

**RPVT Registered Patients and Visits by Tribe**

**RPVS Registered Patients and Visits by SU of Residence**

All three of these report options search the patient files and print the following:

1. The number of living patients registered at the facility or SU you selected.
2. The number of patients receiving any service.
3. The number of PCC services (visits) by those patients.
4. The number of APC visits by those patients.
5. The number of APC primary care provider visits (PCP) by those patients.

The report may be sorted by Community of Residence, Tribe of Membership, or Service Unit of Residence.

You are able to select which portions of the patient database are included in the report by responding to various questions at the beginning of the report generation. Help screens are available to assist you with responding to these questions. Definitions of the following are also available in help screens: Registered Patients, Patients Receiving a Service, PCC Services (All PCC Visits), APC Visits, PCP Visits.

The following is a sample RPVC report.

---



---

SELLS HOSPITAL/CLINIC FEB 5, 1995 Page 1

Registration and Visit Counts for all Patients Registered at  
SELLS HOSPITAL/CLINIC Facility.

The report is sorted by Community of Residence.  
A '\*' after the Community name indicates a Non-Service Unit Community.  
Visit Counts between SEP 1, 1994 and DEC 31, 1994.

Current Community of residence	Reg Pts Living As of Today	Patients Rec'ing Service	All PCC Srvs	APC Visits	PCP Visits
ALI OIDAK	6	3	4	3	3
ANEGAM	6	3	3	1	0
ARIVACA*	5	1	1	0	0
ARTESA	5	1	1	1	1
KAKA	8	0	0	0	0
LITTLE TUCSON	6	0	0	0	0
MARANA	1	1	10	7	7
Total:	37	9	19	12	11

---



---

## AGE Registered Patients by Age, Sex, Tribe, Community (Age Bucket Report)

The Age Bucket Report describes the demographics and epidemiology of a service population. You may define the parameters for the age groups that appear across the top of the page or you may use the predefined groups. Sex, Tribe of Membership, or Community of Residence display down the left side of the page. Cross-tabulations and column subtotals also display.

The report includes all living patients registered through patient registration at the facility or Service Unit you select.

TRIBE OF MEMBERSHIP By AGE GROUP									Page 1
All Living Patients Registered at SELLS HOSPITAL/CLINIC									
JAN 26, 1995									
TRIBE OF MEM	AGE GROUPS								TOT
	0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	
ALASKAN INDI	.	.	.	.	.	1	.	.	1
APACHE	.	2	.	.	1	1	2	.	6
ARAPHOE TRIB	.	.	.	1	.	.	.	.	1
CHEMEHUEVI T	.	.	1	.	.	1	.	.	2
CHEROKEE NAT	.	.	.	1	1	.	1	.	3
CHINESE	.	.	.	.	.	.	1	.	1
COCOPAH TRIB	.	.	.	.	.	1	.	.	1
CREEK NATION	.	.	1	.	.	1	.	.	2
CROW TRIBE O	.	.	.	1	.	1	.	.	2
DAKOTA (SIOU	.	.	.	.	1	.	2	.	3
TOHONO O'ODH	.	21	77	38	42	136	68	61	443
UNSPECIFIED	.	3	.	.	3	1	.	.	7
<b>TOTAL</b>	<b>0</b>	<b>26</b>	<b>79</b>	<b>41</b>	<b>48</b>	<b>143</b>	<b>74</b>	<b>61</b>	<b>472</b>

---

**ACC Active Patient Count by Community of Residence**

**ACS Active Patient Count by SU of Residence**

**ACT Active Patient Count by Tribe**

All three report options search the patient file and print the following:

1. The number of living patients registered at the facility or SU selected.
2. The number of active patients registered at the facility or SU selected.

The report may be sorted by Community of Residence, Tribe of Membership, or Service Unit of Residence, depending on the option you select.

You are able to select which portions of the patient database are included in the report by responding to various questions at the beginning of the report generation. Help screens are available to assist you with responding to these questions. Definitions of Registered Patients and Active Patients are also available in help screens.

The following is a sample ACT report.

---



---

SAN XAVIER HEALTH CENTER	FEB 5,1995	Page 1
Registration and Active Patient Counts for all Patients Registered in SELLS Service Unit.		
The report is sorted by Tribe of Membership.		
Active Patients were those seen between OCT 01,1994 and FEB 5,1995.		
Tribe of Membership	Reg Pts Living As of Today	Active Patients
ALASKAN INDIAN	1	1
NON-INDIAN BENEFICIARY	1	1
TOHONO O'ODHAM NATION OF ARIZONA	91	61
Total:	93	63

---

## CH Community Health Profile Summary

The Community Health Profile Summary presents a profile of health care for patients who reside in the particular community or communities that you select. This report allows you to compare the clinical data from selected communities with that of the entire Service Unit. The data categories included in this report are:

- Patient Registration
- Top 15 POVs for Direct, Contract, and Outpatient Visits
- Top 15 Inpatient Diagnoses
- Leading Surgical Procedures
- Top 10 Causes of Injuries
- Top Dental Services

To generate the report, you will enter a date range and identify the community or communities of interest. The following report was generated for the Little Tucson community in the Sells Service Unit for the 1995 calendar year.

---

Apr 19, 1996 Page 1

\*\*\*\*\* COMMUNITY HEALTH PROFILE \*\*\*\*\*  
 Jan 01, 1993 to Dec 31, 1995  
 LITTLE TUCSON

There are 274 living patients registered at SELLS HOSPITAL/CLINIC.  
 173 received health care services during this time period.  
 8 are currently enrolled in Medicare Part A; 14 in Medicare Part B;  
 100 in Medicaid; and 11 have Private Insurance.

There were 3 births and 1 deaths during this period.

AGE/SEX Distribution as of Apr 19, 1996											
	0-4	5-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80 +	TOTAL
MALE	12	11	16	28	22	21	13	7	4	2	136
FEMALE	16	14	14	33	19	12	14	5	8	1	137
TOTAL	28	25	30	61	41	33	27	12	13	3	273

The Top 15 Purposes of Direct and Contract Outpatient Visits were:  
 Both Primary and Secondary Diagnoses are included

LITTLE TUCSON	SELLS Service Unit
DM UNCOMPL/T-II/NIDDM,NS (169)	DENTAL EXAMINATION (4409)
DENTAL EXAMINATION (162)	DM UNCOMPL/T-II/NIDDM,NS (4289)
HYPERTENSION NOS (104)	CHRONIC RENAL FAILURE (3395)
COUNSELING,NOS (80)	ENCTR EXTRACORP DIALYSIS (2710)
OTH ACQ LIMB DEFORMITY (70)	ISSUE REPEAT PRESCRIPT (2285)
OTITIS MEDIA NOS (41)	HYPERTENSION NOS (2133)
PHYSICAL THERAPY NEC (39)	OTITIS MEDIA NOS (1749)
ACUTE URI NOS (33)	ACUTE URI NOS (1568)
IMPETIGO (32)	SUPERVIS OTH NORMAL PREG (1503)
CHRONIC ULCER OF LEG (29)	COUNSELING,NOS (1413)
ISSUE REPEAT PRESCRIPT (24)	ASTHMA W/O STATUS ASTHM (1297)
URIN TRACT INFECTION NOS (23)	RHEUMATOID ARTHRITIS (1160)
DERMATOPHYTOSIS OF FOOT (20)	URIN TRACT INFECTION NOS (930)
ASTHMA W/O STATUS ASTHM (18)	BRONCHITIS NOS (834)
ANKYLOSING SPONDYLITIS (15)	DERMATOPHYTOSIS OF FOOT (768)

February 1997

The Top 15 Inpatient Diagnoses were:

LITTLE TUCSON		SELLS Service Unit	
-----		-----	
URIN TRACT INFECTION NOS	(23)	DM UNCOMPL/T-II/NIDDM,NS	(109)
HYPOPTASSEMIA	(18)	HYPERTENSION NOS	(53)
HYPERTENSION NOS	(17)	CELLULITIS OF LEG	(43)
CHRONIC ULCER OF LEG	(15)	ALCOHOL DEP NEC/NOS-UNSPEC	(41)
PNEUMONIA, ORGANISM NOS	(10)	URIN TRACT INFECTION NOS	(39)
DIS PLAS PROTEIN MET NEC	(10)	POSTSURG AFTERCARE NEC	(38)
ANEMIA NOS	(8)	OBESITY	(30)
STAPHYLOCOCC SEPTICEMIA	(7)	HYPOVOLEMIA	(15)

The Leading Surgical Procedures were:

LITTLE TUCSON		SELLS Service Unit	
-----		-----	
EXCISIONAL DEBRIDEMENT WO	(13)	EXCISIONAL DEBRIDEMENT WO	(402)
INJECT ANTIBIOTIC	(9)	INJECT ANTIBIOTIC	(140)
NAIL REMOVAL	(5)	VAGINOSCOPY	(98)
INJECT/INFUSE ELECTROLYT	(3)	INJECT/INFUSE ELECTROLYT	(47)
DRESSING OF WOUND NEC	(2)	APPLICATION OF SPLINT	(38)
APPLICATION OF SPLINT	(1)	NAIL REMOVAL	(30)
PACKED CELL TRANSFUSION	(1)	TOOTH EXTRACTION	(17)

The Top 10 Causes of Injury were:

LITTLE TUCSON			SELLS Service Unit	
-----			-----	
ASSAULT NOS	(16)		FALL NEC NOS	(185)
FALL NEC NOS		(14)	ASSAULT NOS	(121)
STRUCK BY OBJ/PERSON NEC	(7)		TRAFFIC ACC NOS-PERS NOS	(47)
FIRE ACCIDENT NOS	(3)		ACC-CUTTING INSTRUM NEC	(35)
HORNET/WASP/BEE STING	(1)		STRUCK BY OBJ/PERSON NEC	(34)
			DOG BITE	(7)
			STRUCK IN SPORTS	(6)

The Top Dental Services were:

LITTLE TUCSON		SELLS Service Unit	
-----		-----	
PATIENT REVISIT	(54)	PATIENT REVISIT	(2311)
FIRST VISIT	(44)	FIRST VISIT	(2062)
OTHER DRUGS/MEDICAMENTS	(36)	OTHER DRUGS/MEDICAMENTS	(1004)
INTRAORAL PERIAPICAL, SIN	(26)	ORAL EXAMINATION, INITIAL	(987)
ORAL EXAMINATION, INITIAL	(22)	INTRAORAL PERIAPICAL, SIN	(977)

End of Report. This report is based on visit data processed on the SELLS HOSPITAL/CLINIC computer.

RUN TIME (H.M.S): 0.1.19  
End of report. HIT RETURN:

---

## CHWL    Clinic Hourly Workload Report

This report generates a 24-hour period visit count by clinic for a date range you specify. The report counts ALL visits, EXCEPT the following:

### Visit Types

- Contract
- VA

### Visit Service Categories

- Chart Review
- In-Hospital
- Ancillary
- Hospitalizations
- Events
- Telecommunications
- Visits WITHOUT a Primary Provider and Purpose of Visit.

You will enter the beginning and ending report date, the facility, the clinic(s), patient age range, and whether visits for all providers or one specific provider will be included. The report provides totals by hourly time frames.

**Note:** Visits must have a Primary Provider and Purpose of Visit to be included in this report.

The sample report below is a workload report for the Emergency Medicine clinic from July 12 to July 14, 1996. The data reported includes patients from 1 to 18 years of age only. The facility selected is Sells Hospital and data for all providers is included.

---

CLINIC HOURLY WORKLOAD REPORT  
LOCATION OF VISITS: SELLS HOSPITAL/CLINIC  
CLINIC: EMERGENCY MEDICINE  
VISIT DATES: JUL. 12, 1994 TO JUL 14, 1996  
AGE RANGE: 1-18

DATE	DOW	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5P	6P	7P	8P	9P	10P	11P	12P
07/12	MON	.	.	.	.	.	.	.	.	2	.	10	10	8	2	10	1	.	.	.	.	.	.	.	.	.
07/13	TUE	.	.	.	.	.	.	.	.	1	.	10	10	8	2	10	1	.	.	.	.	.	.	.	.	.
07/14	WED	.	.	.	.	.	.	.	.	1	.	10	10	8	2	10	1	.	.	.	.	.	.	.	.	.
TOTALS		.	.	.	.	.	.	.	.	4	.	30	30	24	6	30	3	.	.	.	.	.	.	.	.	.

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## INPT Inpatient Reports

This set of reports provides data on inpatient admissions and discharges entered into the PCC database. The following reports are available:

*****	
**	PCC Management Reports **
**	Inpatient Reports **
*****	
Version 3.0	
SELLS HOSPITAL/CLINIC	
HDM	Hospital Discharges by Month of Discharge(2A)
HDD	Hospital Discharge Listing By Date
IICD	Hospital Discharge Listing By DX or Procedure
HDT	Hospital Discharge by Taxonomy (Template/Create)
ADER	Admissions from the ER

## **HDM Hospital Discharges by Month of Discharge (2A)**

This report prints a monthly tabulation showing the number of direct (IHS, 638, or Tribal) inpatient discharges by month of discharge.

The report shows FY-to-date monthly totals for all facilities in the IHS AREA you specify. Each facility displays on a separate line. Monthly and location totals also display.

The report must print on 132-column paper or a printer set up for condensed print.

A sample HDM report is shown on the following page.

---

AREA: 00      TUCSON

NUMBER OF HOSPITAL DISCHARGES BY MONTH OF DISCHARGE

Fiscal Year 94  
OCT 07, 1994

Page 1

---

	YR-TO DATE	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT
SELLS HOSPITAL/CLINIC	29	3	2	1	2	3	1	4	6	1	1	1	3
SAN XAVIER HEALTH CENTER	14	0	1	4	0	0	0	1	4	2	0	1	1
TOTAL	43	3	3	5	2	3	1	5	10	3	2	2	4

---

**HDD Hospital Discharge Listing by Date**

This report provides hospital discharges for your patient population. The report displays the admitting and discharge date, patient chart number, and the discharge service. You may sort by date of discharge or location of encounter.

---

HOSPITAL DISCHARGES FOR SEPT. 1994		FEB 5,1995 19:27	PAGE 1
PATIENT NAME	CHART #	ADMIT DATE	DISCHARGE SERVICE
-----			
DATE OF DISCHARGE: SEP 9,1994			
PETERS, BILL	11427	SEP 4,1994	SURGERY
BROWN, MARY	09422	SEP 1,1994	GENERAL MEDICINE
MILLER, CHERYL	61711	AUG 20,1994	OBSTETRICS
JOHNSON, CHERYL	14190	SEP 1,1994	PEDIATRICS
SMITH, DARLENE	61492	SEP 5,1994	OBSTETRICS
JOHNSON, LARRY	61256	AUG 31,1994	PEDIATRICS
SMITH, DAVID	90311	SEP 2,1994	PEDIATRICS
MILLER, IRMA	23191	SEP 3,1994	PEDIATRICS
BLACK, LARRY	17655	AUG 10,1994	SURGERY
WHITE, MARY	89256	AUG 25,1994	PEDIATRICS
MILLER, JIM	25259	SEP 5,1994	NEWBORN
MARTIN, IRMA	21117	AUG 31,1994	PEDIATRICS
JONES, SAM	26262	SEP 7,1994	NEWBORN
JOHNSON, CHERYL	20629	SEP 1,1994	OBSTETRICS
-----			
COUNT 14			

---

**Estimated Run Time:** Processing time for this report may be lengthy, depending on the date range that you specify. If you are using a date range greater than one month, you may want to queue this report to run at night or after regular hours. Please contact your local Site Manager if you have any questions about queuing this report.

## ICD Hospital Discharge Listing by DX or Procedure

This option prints a list of hospitalization visits by discharge date or admission date. You can select visits by ICD or Procedure code and treatment specialties. Also, you can print data for selected providers. The report prints ICD codes and narratives for all diagnoses and procedures.

First, enter the facility name. Then specify whether you are interested in discharge dates or admission dates and enter the beginning and ending dates for the report. You can specify visits to print for a particular treating specialty, if desired.

You will need to choose one of four reports: (1) all hospitalization visits for the selected dates; (2) only those visits within a selected diagnosis code range; (3) visits within a selected procedure code range; or (4) visits for selected providers. You may use a pre-defined taxonomy of ICD Diagnoses.

The report lists all Inpatient Discharges that meet the criteria you entered during the time period specified. The report displays in alphabetical order by patient name. The following items display for each admission:

- Patient's Name
- Chart Number
- Age
- Admission and Discharge Dates
- Provider Discipline Code
- ICD Codes
- Provider Narrative

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

ADAM 4:14 pm FEB 8,1995	SELLS HOSPITAL/CLINIC HOSPITALIZATION DISCHARGES for 09/09/94 to 09/09/94	Page 1
-------------------------------	---	--------

  

NAME	HRCN	AGE	VISIT DATES	PRV	ICD	PROV NARRATIVE
BLACK, LARRY	18294	57	08/10/94-09/09/94	00	V54.8 250.00 365.9 93.22	OPEN REDUCTION INTER DIABETES MELLITUS GLAUCOMA AMBULATION, GAIT TRA
BROWN, MARY	12371	10209	01/94-09/09/94	00	285.9 578.9 585.	POSS ANEMIA POSS GASTROENTERITIS CHRONIC RENAL FAIL
GARCIA, ALFREDO	20610	4	09/08/94-09/09/94	00	774.6	NEONATAL HYPERBILIRU

**Estimated Run Time:** Processing time for this report may be lengthy, depending on the parameters that you specify. You may want to queue this report to run at night or after regular hours. Please contact your local Site Manager if you have any questions about queuing this report.

## **HDT Hospital Discharge by Taxonomy (Template/Create)**

This report option creates a search template of patients based on their hospital discharge date and diagnosis. The template you create can then be used with many report options to display data for only those patients stored in the template. The template will allow for faster report generation because the entire database does not need to be searched each time you need to print data for this group of patients.

The patients selected for inclusion in the template will be living patients who have a discharge date within the time frame you specify. They must also have a primary diagnosis that is in the diagnosis taxonomy you select.

The report excludes the following categories:

- patients discharged before 10 days old
- patients whose length of stay in the hospital was less than 1 day
- patients whose primary diagnosis is not in the user-selected taxonomy

You will first be prompted to enter a beginning and ending discharge date for the patient search. Next you will enter the name of a diagnosis taxonomy. Note that this taxonomy must have been defined previously. This report option does not allow you to create a diagnosis taxonomy. See your Site Manager for assistance if you need to create a diagnosis taxonomy.

Finally, you will enter the name of the search template in which the patients will be stored. You can save them in an existing template or create a new one. If you are saving the patients in an existing taxonomy, this new group of patients will replace the group of patients that was previously stored in that template.

When you have finished entering your search criteria, the following message appears indicating the number of patients that were found and stored in the template.

---

An unduplicated patient list resulting from this report will be stored in the

    \*\* DM PATIENTS>60 YEARS   \*\* Search Template.

OKAY -- HOLD ON WHILE I FIND ALL THE DISCHARGES.....

ALL DONE - FOUND 47 PATIENTS.

---

---

**ADER Admissions from the ER**

This report produces a list of admissions from the ER for a specified date range. Note that this option searches the patient file for any admissions that occurred on the same day as a visit to the ER so the admissions listed may not have been directly from the ER.

---



---

SELLS HOSPITAL/CLINIC						Page 1
HOSPITAL ADMISSIONS AFTER ER VISIT						
VISITS DATES: JAN 01, 1990 TO DEC 30, 1995						
NAME	HRCN	VISIT DATE&TIME	CLN FAC	ICD	PROVIDER NARRATIVE	
GRANT,EDITH	SE 100507	01/01/90		SE 289.3	LYMPHADENITIS	
				706.2	L NECK CYST INFECTE	
ER Visit Information =>		01/01/90 17:00	30 SE	289.3	LYMPHADENITIS	
				706.2	INFECTED NECK CYST	
WHEELWRIGHT,RAC	SE 101308	01/26/90		SE 648.21	VAGINAL DELIVERY,AN	
				661.31	PRECIPITOUS TERM VA	
ER Visit Information =>		01/26/90 06:35	30 SE	663.91	NUCHAL CORD X1	
				661.31	NSVD PRECIPITOUS DE	
VON RICHTOFEN,A	SE 101622	01/07/90		SE 486.	RIGHT MIDDLE LOBE P	

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## QA Quality Assurance Reports

This series of PCC Reports displays patient visit data with ICD Code information or APC recode information.

The following options are available from the Quality Assurance Reports menu:

```
*****
**      PCC Management Reports      **
**      Quality Assurance Reports   **
*****
          Version 3.0

          SELLS HOSPITAL/CLINIC

AUD      Random Sample of Visits by DX and Date
CICD     Listing of Visits by Clinic Type and by Diagnosis
INPT     Hospital Discharge Listing By DX or Procedure
VICD     Listing of Outpatient Visits with ICD Codes
A        Returns to ER w/in 72 Hrs After Clinic Visit
ADA      Listing of Clinic Visits with ADA Codes
CZIP     Clinic Visit Counts by Clinic Type by Zip Code
CVC      Clinic Visit Counts Within a Date Range
NVST     Patients with AT LEAST N Visits
INJ      Listing of Visits with Injury Diagnosis
PVC      Provider Visit Counts
PVCT     Provider or Clinic Visit Counts by Template of Patients
VGEN     Visit General Retrieval
DEL      Delete VGEN/PGEN Report Definition
RADM     Readmissions Within 30 Days of a Discharge
VST      Display Single Visit for a Patient ...
```

## **AUD Random Sample of Visits by Diagnosis and Date (PCC Audit Search)**

This report searches the PCC database for ambulatory visits that match user-defined criteria. The audit search offers two choices: (1) **RANDOMLY** select a user-defined number of visits that match the search criteria for each provider and diagnostic range; or (2) **ALL** visits that meet the search criteria. This routine identifies and retrieves visit information for targeted quality assurance surveys.

You will define the following search criteria:

- Visit Date range
- Patient Age group
- Service Category
- Visit Type
- Clinic Type
- Location of Encounter
- ICD Diagnostic Code ranges

Only visits meeting the user-defined criteria will display in the report. If you select the search to include all providers or selected providers, the search displays POVs by provider. Alternatively, you can ignore the provider entirely. Finally, you can ask for all POVs that match the criteria or retrieve a random sample of any desired number of matching POVs. The report of matches displays by provider and POV. For example, if you select provider and 10 random POVs in the search criteria, the report displays 10 POVs per provider for the specified ICD Diagnostic range.

The first page of the report displays the search criteria selected for generating the report. The remainder of the report displays Chart Number, Visit Date, Primary Provider, ICD code, and ICD Diagnostic Narrative.

**Note:** If you request a random sample, the report displays the total number of POVs matching the selection criteria before the random selection. If the number of matching visits is less than the number that you requested to display, all the visits display. For example, if you request 5 random samples but only 4 visits match your selection criteria, 4 visits display.

A sample report is provided on the following page.

SELLS HOSPITAL/CLINIC

FEB 6,1995

Page 1

Audit Search for Ambulatory Visits from SEP 1,1994 through SEP 30,1994.

HRCN	Visit Date ICD9	Primary Provider DIAGNOSIS	Patient Name	DOB
17210	SEP 9,1994 401.9	LOGAN,DAVID HTN	BLACK,ANNE	02/01/26
904	SEP 9,1994 401.9	PHYSICIAN,IHS HYPERTENSION NOS	GREEN,SAM	06/01/45
2545	SEP 13,1994 401.9	SHORE,GREG HYPERTENSION NOS	JOHNSON,MARY	05/01/45
12372	SEP 15,1994 401.9	SHORR,GREG HYPERTENSION NOS	MILLER,CHERYL	12/01/48

**Estimated Run Time:** Run time for this report is a function of the date range and number of selection criteria chosen. The report processing time may be short for a small date range or longer for a larger date range. You may want to queue this report to print after hours. Please contact your local Site Manager if you have questions regarding queuing this report.

## CICD Listing of Visits by Clinic Type and by Diagnosis

This option allows you to print a list of clinic visits by Clinic and by ICD Code for a specific date range. If desired, the report can be very specific. First, enter the range of visit dates and select to display all clinics, one clinic, or no clinic. Then choose one of three reports: (1) all visits for the specified dates and clinic(s) regardless of ICD codes; (2) all visits that match a diagnostic code range; or (3) all visits that match a procedure code range. Only visits for the site you are logged in to will display on the report. The report displays in alphabetical order by patient name.

**Note:** To print only those visits with no associated clinic code (excluding hospitalizations), enter 0 when asked if you want to print all clinics.

### The visits included must meet the following criteria:

- Must not be deleted.
- Must be for the site that you logged in to.
- Must **not** be for the following service categories:
  - Hospitalization
  - Observation
  - Events
  - In-Hospital
- Must not be a contract or VA visit type

### The following displays for each Clinic Visit:

- Patient's Name
- HRN
- Age
- Visit Date
- Provider Discipline Code
- ICD Codes
- Provider Narrative

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

5:55 PM FEB 6,1995	SAN XAVIER HEALTH CENTER CLINIC VISITS FOR GENERAL (01) for 09/01/94 to 09/30/94	Page 1
NAME	HRCN AGE VISIT DATE/TIME PRV ICD	PROV NARRATIVE
BLACK, BOB	90778 49 09/09/94 0800 11 V68.1	DM MED REFILL 918.1 CORNEAL ABRASION
BLACK, JOHN	11908 19 09/09/94 0910 00 V68.1	HTN MED REFILL
BLACK, LARRY	17655 57 09/09/94 0830 30 V72.6	LAB
BLACK, THERESA	78556 68 09/09/94 1600 00 V68.1	DIABETES MED REFILL 413.9 POSSIBLE ANGINA 715.90 OSTEOARTHRITIS
BROWN, DAVID	90664 3 09/09/94 1334 00 381.4	BILATERAL SEROUS OM
BROWN, DENNIS	16745 49 09/09/94 0915 21 V58.3	DRESSING CHANGE, ULCER,
TOTAL PATIENTS FOR CLINIC: 6		
TOTAL VISITS FOR CLINIC: 6		

**Estimated Run Time:** Run time for this report is a function of the date range and number of selection criteria chosen. The report processing time may be short for a small date range or longer for a larger date range. You may want to queue this report to print after hours. Please contact your local Site Manager if you have questions regarding queuing this report.

## INPT Hospital Discharge Listing by Diagnosis or Procedure

This option allows you to print a list of hospitalization visits by Discharge Date or by Admission Date. The visits include your facility only; however, you may identify treating specialties. The list includes ICD Codes and Narratives for all diagnoses and procedures. You have the option of displaying only those visits that contain ICD codes within a given range.

The following information displays for each admission:

- Patient's Name
- HRN
- Age
- Admission and Discharge dates
- Provider Discipline code
- ICD Codes
- Provider Narrative

First, specify a range of Admission or Discharge Dates. Then choose whether you want the report limited to a treating specialty. Finally, select one of three reports: (1) all hospitalization visits for the selected dates; (2) visits within a selected Diagnostic Code range; or (3) visits within a Procedure Code range.

The report displays in alphabetical order by Patient Name. A sample report is included below.

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

NAME	HRCN	AGE	VISIT DATES	PRV	ICD	PROV NARRATIVE
BLACK, LARRY	18294	57	08/10/94-09/09/94	00	V54.8 V57.89 250.00 365.9 93.22	OPEN REDUCTION INTER OPEN REDUCTION INTER DIABETES MELLITUS TY GLAUCOMA AMBULATION, GAIT TRA
BROWN, MARY	12371	46	09/01/94-09/09/94	00	285.9 578.9 585.	POSSIBLE ANEMIA OF C POSSIBLE GASTROINTES POSSIBLE CHRONIC RE
GARCIA, ALFREDO	20610	4	09/08/94-09/09/94	00	774.6	NEONATAL HYPERBILIRU
JOHNSON, ANNE	19066	4	08/05/94-09/09/94		486. 558.9	PNEUMONIA GASTROENTERITIS
JOHNSON, CHERYL	19662	24	09/01/94-09/09/94	00	661.21 73.59	IUP LABOR.PP HEMORRH SPONTANEOUS VAGINAL
JOHNSON, LARRY	16661	11	08/31/94-09/09/94	74	854.00	HEAD TRAUMA, CONTUSI

## VICD Listing of Outpatient Visits with ICD Codes

This report lists all outpatient visits for a specific time at the RPMS facility you are logged in to.

The visits in this report must meet the following criteria:

- Must be for the facility you are logged in to.
- Must not be a Contract or VA type visit.
- Must be one of the following service categories: Ambulatory, Day Surgery, or In-Hospital.
- Must not be a Dental Clinic visit.

The following information will be displayed for each Visit:

- Patient's Name
- HRN
- DOB
- Medicare #
- Visit Date
- Provider Discipline code
- First/Revisit Code
- ICD Codes
- Provider Narrative

The report is presented in alphabetical order by Patient Name.

**Note:** You must print this report on a 132-column-width printer or a printer set up for condensed print.

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

FEB 7, 1990	SAN XAVIER HEALTH CENTER ALL OUTPATIENT VISITS (excluding dental) for 09/01/88 to 09/30/88	Page 1
NAME	HRCN      DOB      MEDICARE#	VISIT DATE    PROV    F/R    ICD    PROV NARRATIVE
BLACK, ANNE	78556    02/01/26	09/09/88    00    2    V07.9    IMMUNIZATION 2    250.00    DM TYPE II 2    401.9    HYPERTENSION
BLACK, BOB	67445    12/01/40	09/09/88    11       V68.1    MED REFILL 918.1    CORNEAL ABRAS
BLACK, CHERYL W/AS	78556    08/01/11	09/09/88    00    2    250.00    DIABETES 09/09/88    08    1    367.0    HYPEROPIA 1    367.4    PRESBYOPIA 1    379.31    APHAKIA OU
BLACK, JOHN	11908    08/01/70	09/09/88    00    2    V68.1    MED REFILL
BLACK, LARRY	17655    11/01/32	09/09/88    30       V72.6    LAB
BLACK, THERESA	89532    06/01/21	09/09/88    00    2    428.0    F/U POSS CHF 1    645.9    URI

## A Returns to ER within 72 Hours After Clinic Visit

This report produces a list of patient visits resulting in a return to the emergency room within 72 hours of the clinic visit. Select a beginning and ending visit date range, the Clinic in which the patient was initially seen, and the Location of the Visit.

This list of visits can potentially be used for Ambulatory Indicator A-1 of the Maryland Hospital Association Project.

---



---

NAME	HRCN	VISIT DATE&TIME	CLN	FAC	ICD	PROVIDER NARRATIVE
SELLS HOSPITAL/CLINIC <span style="float: right;">Page 1</span>						
ER VISITS AFTER CLINIC VISITS						
VISITS DATES: JAN 01, 1994 TO DEC 31, 1995						
-----						
THATCHER, BECKY	SE 256413	05/09/94 12:00	30	SE	401.9	HTN
		05/12/94 12:00	30	SE	250.00	DM II
WATERMAN, ANTHON	SE 103111	09/12/94 10:00	01	SE	250.00	DM
		09/13/94 17:30	30	SE	250.30	DIABETIC COMA
WATERMAN, RAE	SE 103111	09/11/94 12:00	52	SE	278.0	MORBID OBESITY/NUTR
		09/13/94 17:30	30	SE	250.30	DIABETIC COMA
ENOS, DON	SE 100041	02/06/95 12:00	14	SE	250.00	DM
		02/06/95 12:00	30	SE	401.9	HTN
THOMAS, RITA	SE 256413	02/08/95 12:00	14	SE	311.	DEPRESSIVE DISORDER
		02/08/95 12:00	30	SE	311.	DEPRESSIVE DISORDER
ADAMS, ROSE	SE 3061	11/01/95 09:00	01	SE	250.00	DM
					401.9	HTN
					382.9	OTITIS MEDIA
		11/01/95 23:00	30	SE	382.9	OM - FOLLOW UP
					487.1	FLU
					514.	PULMONARY CONGESTIO
RUN TIME (H.M.S): 0.0.6 End of report. HIT RETURN:						

---



---

## ADA Listing of Clinic Visits with ADA Codes

This report lists all visits with associated ADA codes for a specific time period. You will specify the date range and Location of Visit. A report may be generated for selected clinics or all clinics.

The report displays the following information:

- Patient name
- Health Record Number (HRN)
- Age
- Visit Date
- Primary Provider Discipline
- ADA Code
- Provider Narrative

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

3:21 pm  
FEB 7, 1996
SELLS HOSPITAL/CLINIC  
CLINIC VISITS FOR DENTAL (56)  
for 01/01/96 to 01/31/96
Page 1

NAME	HRCN	AGE	VISIT DATE	PRV	ADA	PROV NARRATIVE
ADAMS, CHASE	102121	11	01/21/96 0100	52	0000	DENTAL/ORAL HEALTH VISIT
BETZ, CHRISTOP	102342	24	01/08/96 0414	52	0120	DENTAL EXAMINATION
			01/30/96 1000	52	0120	DENTAL/ORAL HEALTH VISIT
DILBERT, DEE	100572	33	01/04/96 1100	52	0000	OTHER DENTAL
GOMEZ, FELIX	103126	61	01/06/96 1200	52	0130	DENTAL EXAMINATION
JACKS, GREG	101738	11	01/21/96 0400	52	0120	DENTAL/ORAL HEALTH VISIT
			01/25/96 0000	52	0000	OTHER DENTAL
LOPEZ, IRMA	102600	56	01/16/96 0200	52	0130	DENTAL EXAMINATION
PRATZ, JENNIFE	100044	65	01/13/96 0130	52	0000	DENTAL CARIES

TOTAL PATIENTS FOR CLINIC: 7

TOTAL VISITS FOR CLINIC: 9

RUN TIME (H.M.S): 0.0.1  
End of report. HIT RETURN:

---

## CZIP Clinic Visit Counts by Clinic Type by Zip Code

This report generates a count of visits by Clinic Type and by Zip Code for a date range that you specify. The report provides subtotals by Location of Encounter.

All visits in the database will be included in the tabulation with the EXCEPTION of the following:

- |  |  |
|--|--|
| <b>Visit Types:</b> <ul style="list-style-type: none"> <li>• Contract</li> <li>• VA</li> </ul> | <b>Visit Service Categories:</b> <ul style="list-style-type: none"> <li>• Chart Review</li> <li>• In-Hospital</li> <li>• Hospitalizations</li> <li>• Historical Events</li> <li>• Telephone Calls</li> </ul> |
|--|--|

**Note:** Visits must have a Primary Provider and Purpose of Visit in order to appear in this report.

APR 04, 1996

Page 1

NUMBER OF AMBULATORY VISITS BY CLINIC TYPE  
 LOCATION OF VISITS: ALL  
 VISIT DATES: JAN 01, 1995 TO JAN 04, 1995

LOCATION OF VISIT	TYPE OF CLINIC (CODE)	ZIP CODE	# VISITS
-----			
SELLS HOSPITAL/CLINIC			
	ALCOHOLISM PROGRAM (43)	88776	3
		Clinic Total:	3
	CHRONIC DISEASE (50)	88776	1
		Clinic Total:	1
	DENTAL (56)	88776	4
		Clinic Total:	4
		Location Subtotal:	----- 8

---

---

## CVC Clinic Visit Counts within a Date Range

This report counts clinic visits within a specified date range. You may run the report for a specific clinic or for all clinics.

The following sample report lists visits to the General Clinic for January 1, 1994 to February 28, 1994.

---

LAB  
4:54 pm  
JUL 28,1994

SELLS HOSPITAL/CLINIC  
VISIT COUNTS FOR GENERAL (01) CLINIC  
for 01/01/94 to 02/28/94

Page 1

VISIT DATES	NUMBER OF VISITS
01/11/94	12
01/13/94	10
01/15/94	18
01/17/94	9
01/20/94	8
01/22/94	14
01/25/94	10
01/29/94	6
02/04/94	9
02/08/94	20
02/11/94	13
02/12/94	11
02/15/94	10
02/27/94	10
 TOTAL VISITS FOR CLINIC	 160

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## NVST Patients with AT LEAST N Visits

This report produces a list of patients who had at least N clinic visits within a specified time frame. The patient's name, chart number, sex, date of birth, location, provider, diagnosis codes, and number of visits display in the report.

You will first enter a beginning and ending date for the report time frame and then specify the minimum number of visits in order for a patient to be included in the report.

Next you have the option of selecting the specific patients who will be included in the report. You will be able to browse the following list on the screen and then enter the screening criteria. You can select patients based on any combination of the following data items:

### Selection Criteria

- |                          |                             |                            |
|--------------------------|-----------------------------|----------------------------|
| 1) Name                  | 22) EDC Determination       | 42) Prim/Sec Prov Affil    |
| 2) Sex                   | 23) Last Menstrual Period   | 43) Diagnosis Code         |
| 3) Date of Birth         | 24) Time of Visit           | 44) Primary Dx (POV)       |
| 4) Age                   | 25) Type (IHS,638,etc.)     | 45) Stage of Dx (POV)      |
| 5) Date of Death         | 26) Service Category        | 46) Problem List Dx        |
| 6) Living Pts            | 27) Visit Location          | 47) Alcohol/Work Related   |
| 7) Chart Facility        | 28) Service Unit of Patient | 48) Cause of Dx (POV)      |
| 8) Community             | 29) Outside Location        | 49) Cause of Injury        |
| 9) Tribe                 | 30) Clinic Type             | 50) Place of Injury        |
| 10) Eligibility Status   | 31) Admitting Service       | 51) Operation Code         |
| 11) Beneficiary Class    | 32) Discharge Service       | 52) Dental ADA Codes       |
| 12) Medicare             | 33) Appt/Walk-In            | 53) Immunizations          |
| 13) Medicaid             | 34) Level of Service        | 54) Treatments Provided    |
| 14) Private Insurance    | 35) Eval&Management CPT     | 55) Lab Tests              |
| 15) Medicaid Plan Name   | 36) Length of Stay          | 56) Medications            |
| 16) Pvt Ins Plan Name    | 37) Primary Prov Name       | 57) CPT Code               |
| 17) Priv Ins Verified    | 38) Prim/Sec Prov Name      | 58) Exclude Inactive Pts   |
| 18) Desig Prim Care Prov | 39) Prim Prov Discipline    | 59) Inactive Patients      |
| 19) EDC                  | 40) Prim/Sec Prov Disc      | 60) Excl Incomplete Visits |
| 20) Date EDC Determined  | 41) Prim Prov Affil         | 61) Operating Provider     |
| 21) Contraception Method |                             |                            |

To select patients, enter "S" at the action prompt. At the next prompt, enter the numbers that correspond to your selection criteria. You may enter a list or range of numbers; for example, 1,3,4-10,23. You will then be prompted for the specific categories of interest within the selection criteria you specified; for instance, if you selected to screen patients by age, you would be prompted to enter an age range. After entering these specifications, you will be returned to the selection list where you can modify your choices, if needed. The selections you have already entered will be marked by an asterisk (\*). When you have finished selecting items, type "Q" at the prompt to continue. Note that if you want to include all patients in the report, type "Q" at the action prompt to bypass the selection screen.

You will then be presented with a sort item selection menu. Select one item from the following list to indicate how you would like the report output sorted. If you do not select a sort item, the report will be sorted by patient name. You will select the sort item by following the same process for selecting the search criteria.

**Sort Criteria**

- |                        |                          |                             |
|------------------------|--------------------------|-----------------------------|
| 1) Name                | 9) Community             | 17) Desig Prim Care Prov    |
| 2) Chart #             | 10) Tribe                | 18) EDC                     |
| 3) Terminal Digit #    | 11) Eligibility Status   | 19) Date EDC Determined     |
| 4) Sex                 | 12) Beneficiary Class    | 21) Contraception Method    |
| 5) Date of Birth       | 13) Cause of Death       | 21) EDC Determination       |
| 6) Age                 | 14) Third Party Eligibil | 22) Last Menstrual Period   |
| 7) Date of Death       | 15) Medicaid Plan Name   | 23) Service Unit of Patient |
| 8) Employer of Patient | 16) Pvt Ins Plan Name    |                             |

The following sample report lists patients who have had at least 10 visits between January 1, 1993 and August 5, 1996. All patients were included in the search and report is sorted by patient name.

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Page 1

SELLS HOSPITAL/CLINIC  
 PATIENTS SEEN AT LEAST 10 TIMES  
 VISIT DATES: JAN 01, 1993 TO AUG 05, 1996

PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	DX CODES	# VISITS
CARPENTER, HANNA	100150	F	01/03/23	HOME SELLS HOSP	COMMUNITY	323.9	11
					CURTIS, CLA	919.8	
					DOCTOR, JOS	962.2	
					DOUGLAS, BI	278.00	
					MALDONADO,	300.00	
					MARTIN, GRE	311.	
						820.00	
						V65.9	
MENOS, DON	100041	M	03/05/41	SELLS HOSP	DOUGLAS, BI	280.9	13
					GRAU, DAVID	311.	
					MARTIN, GRE	V26.4	
					SHORR, GREG	V62.82	
						V65.40	
SMITH, FAY	100065	F	04/15/35	HOME	BUTCHER, LO	.9999	11
				SAN XAVIER	DOUGLAS, BI	298.9	
				SELLS HOSP	JONES, BOB	818.1	
					SHORR, GREG	995.5	
						995.81	

RUN TIME (H.M.S): 0.0.7  
 End of report. HIT RETURN:

---

## INJ Listing of Visits with Injury Diagnosis

This report lists visits containing an injury diagnosis (ICD codes 800-999). You can select which visits to print based on any of the following criteria:

- Visit Date
- Clinic of Visit
- Service Category of Visit
- Type of Visit
- Location of Encounter
- Age range

The report includes a cover page that identifies the visit criteria selected.

### SELLS HOSPITAL/CLINIC

The following Injury Report is based on the following criteria:

1. Visits from JAN 1, 1994 through DEC 31, 1994
2. All Locations of Encounter.
3. All Visit Types.
4. All Visit Service Categories.
5. All Clinics.
6. The following Ages: 10 - 65
7. All visits with an ICD9 Diagnosis between 800 and 999 (injury codes).

End of cover page - Hit return:

LAB Page 1  
SELLS HOSPITAL/CLINIC  
Visits with Injury Diagnosis  
Visit Dates: JAN 01, 1994 to DEC 31, 1994

DFN	HRCN	AGE	VISIT DATE	PRV	TYPE	SER CAT
-----						
BROWN,BEN	102542	63	07/28/94 1000	71	IHS	AMBULATORY
ICD9: 806.08	Provider Narrative:		BROKEN LEG			
Cause of Injury:	E928.9 - ACCIDENT NOS					
Date of Injury:	07/28/94	Place of Accident:		UNKNOWN		
SMITH,DALE	101579	12	09/30/94 1100	71	IHS	AMBULATORY
ICD9: 806.08	Provider Narrative:		BROKEN ARM...			
ICD9: 806.00	Provider Narrative:		FALL			
Cause of Injury:	E928.9 - ACCIDENT NOS					
Date of Injury:	09/30/94	Place of Accident:		HOME-INSIDE		

## INJS Injury Visit E-Code Summary Report

The Injury Visit E-code Summary report counts visits that have an injury diagnosis (ICD codes 800-999). You can select which visits to count based on any of the following criteria:

- Visit Date
- Clinic
- Service Category
- Type of Visit
- Location of Encounter
- Age Range

You will be prompted to enter a beginning and ending visit date range for this report. Then you will have the option of screening visits by the additional criteria listed above. If you do not want to screen visits, press RETURN at each of the corresponding prompts to include all visits. If you are screening visits, you will enter NO at the corresponding prompt and then enter the specific variables; for instance, if you are screening visits by clinic, you would enter the specific clinics of interest, such as Internal Medicine and Diabetic. These visit specifications that you select can be saved for future use by assigning a name to each group.

The visit counts in this report are summarized by the following 18 E-Code categories. You can also use these predefined injury code taxonomies with the VGEN report option and print the cause of injury code, place of injury code, and whether the injury was work- or alcohol-related.

Category	E-Code Range	Taxonomy Name
Motor Vehicles	E800.0-E825.9, E929.0, E988.5	APCL INJ MOTOR
Boat/Water	E831.0-E831.9, E833.0-E838.9	APCL INJ WATER TRANSPORT
Air Transport	E840.0-E845.9, E988.5	APCL INJ AIR TRANSPORT
Accidental Poison	E850.0-E869.9, E929.4	APCL INJ POISONING
Environmental Factors	E900.00-E904.9, E907.0-E909.9, E929.5, E988.3	APCL INJ FALLS
Stings/Venoms	E905.0-E905.9, E906.2, E906.4, E906.8, E906.9	APCL INJ FIRE
Falls	E880.0-E888.0, E929.4, E987.0-E987.9	APCL INJ ENVIRONMENTAL FACTORS
Fire/Flame	E890.0-E899.0, E929.4, E988.1-E988.2	APCL INJ STINGS VENOMS
Animal Bites	E906.0-E906.1, E906.3, E906.5	APCL INJ ANIMAL RELATED
Drowning/Submerging	E830.0-E830.9, E832.0-E832.9, E910.4-E910.9	APCL INJ DROWNING
Cutting/Piercing	E920.3-E920.9	APCL INJ CUT
Firearms	E922.0-E922.9, E970.0, E985.0-E985.4	APCL INJ FIREARMS
Sports Injury	E917.0	APCL INJ SPORTS
Suicide	E950.0-E958.9, E983.0	APCL INJ SUICIDE
Assault	E960.0-E966.0, E968.0-E968.9	APCL INJ ASSAULTS
Child Abuse	E967.0-E967.9	APCL INJ BATTERED CHILD
Undetermined	E988.8-E988.9	APCL INJ UNDETERMINED
Other	all others in range 800-999 not listed above	APCL INJ OTHER CAUSES

As shown in the sample report below, a cover page that details the visit selection criteria prints with each report.

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SELLS HOSPITAL/CLINIC

The Surveillance Injury Report is based on the following criteria:

1. Visits from JAN 01, 1996 through FEB 28, 1996
  2. The following Locations of Encounter:  
SELLS HOSPITAL/CLINIC
  3. All Visit Types.
  4. All Visit Service Categories.
  5. The following Clinics:  
EMERGENCY MEDICINE
  6. The following Ages: 18-35
  7. All visits with an ICD9 Diagnosis between 800 and 999 (injury codes).
- 
- 

SELLS HOSPITAL/CLINIC

Page 1

INJURY SURVEILLANCE SUMMARY REPORT  
(E-CODES)

Visits with Injury Diagnosis

Visit Dates:

JAN 01, 1996 to FEB 28, 1996

E-CODE CATEGORY SUMMARY	COUNT	% TOTAL
MOTOR VEHICLE	23	26
WATER TRANSPORT	1	1
AIR TRANSPORT	1	1
ACCIDENTAL POISONING	0	0
ACCIDENTAL FALLS	27	30
FIRES/FLAMES	0	0
ENVIRONMENTAL FACTORS	5	6
STINGS/VENOMS	1	1
ANIMAL RELATED	2	2
DROWN/SUBMERGE	0	0
CUT PIERCING OBJ	4	4
FIREARMS	0	0
SPORTS INJURY	3	3
SUICIDE ATTEMPTS	2	2
ASSAULTS	7	8
BATTERED CHILD	1	1
UNDETERMINED	0	0
OTHER CAUSES	12	13

GRAND TOTAL = 89

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## PVC Provider Visit Counts

This report provides the total number of visits for each provider or provider discipline selected for a specified date range. You must enter a visit date range and a single provider, a single provider discipline, or all providers.

The report prints one page for each provider or provider discipline selected. Each Visit Date and Clinic is displayed and totals by provider are included.

The following visits are included in the report:

- Visits at the facility you are logged in to.
- All Service Categories EXCEPT:
  - Hospitalizations
  - In-Hospital, Events
  - Observation
- All Visit Types EXCEPT:
  - CHS
  - VA

Page 1

6:14 pm  
FEB 6,1995

SAN XAVIER HEALTH CENTER  
VISIT COUNTS FOR FOLSON, MALINDA  
(LICENSED PRACTICAL NURSE)  
for 09/01/94 to 09/30/94

VISIT DATES -----	CLINIC -----	NUMBER OF VISITS -----
09/09/88	EMERGENCY MEDICINE (30)	2
	PODIATRY (65)	1
TOTAL VISITS FOR PROVIDER:		3

Page 2

6:14 pm  
FEB 6,1995

SAN XAVIER HEALTH CENTER  
VISIT COUNTS FOR JOSE, MARY  
(LICENSED PRACTICAL NURSE)  
for 09/01/94 to 09/30/94

VISIT DATES -----	CLINIC -----	NUMBER OF VISITS -----
09/09/94	DIABETIC (06)	2
	GENERAL (01)	3
	PODIATRY (65)	1
TOTAL VISITS FOR PROVIDER:		6

**Estimated Run Time:** Run time for this report is a function of the date range specified. The report processing time may be short for a small date range or longer for a larger date range. You may want to queue this report to print after hours. Please contact your local Site Manager if you have questions regarding queuing this report.

## PVCT Provider or Clinic Visit Counts by Template of Patients

This report tallies the number of visits of a predefined set of patients by Provider or by Clinic. Prior to using this option, you must have already created a search template for a specified group of patients.

The following sample report was created using a template for patients over age 60. The sample shows all visits for this group by provider.

```

*****
*   SELLS HOSPITAL/CLINIC                               APR 12, 1996   Page 1   *
*                                                                 *
*                                                                 *
*                   NUMBER OF VISITS BY PROVIDER           *
*                                                                 *
*                   SEARCH TEMPLATE: PTS OVER 60           *
*****

```

PROVIDER	CLASS	# VISITS
ACOSTA, CHARLENE	LICENSED PRACTICAL N	26
AUDIOLOGIST, CONTRACT	AUDIOLOGIST	15
BLACKOWL, IRENE	CHN/AIDES	266
BUZEK, M T	PODIATRIST	144
CAYCE, WALTER	PHYSICIAN	85
CURTIS, CLAYTON	INTERNAL MEDICINE	47
DODGE, FRANK	PHARMACIST	1349
DOUGLAS, BILL	MENTAL HEALTH	38
ENOS, SUSIE	REGISTERED NURSE	658
FOLSON, MALINDA	LICENSED PRACTICAL N	139
GONZALES, EVELYN	NURSE PRACTICIONER	220
LIVINGSTON, ROBERT	PHYSICIAN	507
LOGAN, DAVID	PHYSICIAN	721
MEDICAL STUDENT	MEDICAL STUDENT	58
MIKE, LUCY	NURSE MIDWIFE	247
NURSE ASSISTANT, IHS	PHYSICIAN	902
NUTRITION WORKER, TRIBAL	NUTRITIONIST	613
NYE, PATRICIA	PSYCHIATRIST	25
ORTEGA, ADRIAN	LICENSED PRACTICAL N	54
PABLO, CLIFFORD	REGISTERED NURSE	235
SHORR, GREG	PHYSICIAN	26
SILAS, ANDREA	CHN/AIDES	72
TOM, EVELYN	PHYSICIAN ASSISTANT	436
WILLIAMS, ANGELITA	PHYSICIAN ASSISTANT	399
WOODFORD, MICHAEL	PHARMACIST	1523
	Total:	----- 8805

RUN TIME (H.M.S): 0.3.44  
End of report. HIT RETURN:

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## VGEN Visit General Retrieval

The Visit General Retrieval produces a list or tally of visits within a specified date range based on various criteria you select. This extremely flexible report option enables you to select which visits to include in the report, which data items to print, and how the data is sorted. Depending on the choices you make, you can generate a very specific report or a very general report. The logic used to produce the report may be saved for future use. You may also limit your search to predefined templates of patients that have been created with Q-Man, Case Management, or other RPMS tools.

If you design a report that is 80 characters or fewer in width, it can be displayed on your screen or printed. If your report is 81-132 characters wide, it must be printed and can only be printed on a printer capable of producing 132 character lines. Each report includes a cover page that details the user-defined criteria.

To begin generating a report using the Visit General Retrieval option, you will need to indicate whether you want to search the entire database or limit your search to a predefined search template. You may use a search template of patients or visits. If your template was created in Case Management or Q-Man using Patients as the search subject, this is a search template of patients. If your template was created in Q-Man using Visits as the search subject, this is a search template of visits. Select one of the following search options:

- P Search Template of Patients
- V Search Template of Visits
- S Search All Visits

Next you will be prompted to enter a beginning and ending date to specify the visit date range of interest. Note that if you are using a search template, be sure that the date range you enter is a subset of, or corresponds with, the template date range.

If you are searching all visits, you can choose to use a previously defined report by entering "Yes" and then the report name at the appropriate prompts. The report will then generate automatically. No further actions are necessary.

### Selecting Search Criteria

If you are creating a new report, you will be presented with a list of visit selection criteria that allows you to select which particular visits to include in your report. The following action items are available for browsing this list and making your selections:

- + Next Screen
- Previous Screen
- S Select Items
- Q Quit Item Selection
- R Remove Items
- E Exit Report

Enter + and - at the Select Action prompt to review the selection items in the list. When you are ready to select items, press return at the prompt to accept Select Items as the default value or enter "S." You can select visits based on any combination of the data items in the list. Enter a list or a range of numbers at the next prompt; for example, 1-4,5,20 or 10,12,20,30. Then you will be prompted to define values for the items you chose, as applicable. For instance, if you selected age, you would be prompted to enter an age range.

**Visit Selection Menu**

- |                          |                             |                            |
|--------------------------|-----------------------------|----------------------------|
| 1) Name                  | 22) EDC Determination       | 42) Prim/Sec Prov Affil    |
| 2) Sex                   | 23) Last Menstrual Period   | 43) Diagnosis Code         |
| 3) Date of Birth         | 24) Time of Visit           | 44) Primary Dx (POV)       |
| 4) Age                   | 25) Type (IHS,638,etc.)     | 45) Stage of Dx (POV)      |
| 5) Date of Death         | 26) Service Category        | 46) Problem List Dx        |
| 6) Living Pts            | 27) Visit Location          | 47) Alcohol/Work Related   |
| 7) Chart Facility        | 28) Service Unit of Patient | 48) Cause of Dx (POV)      |
| 8) Community             | 29) Outside Location        | 49) Cause of Injury        |
| 9) Tribe                 | 30) Clinic Type             | 50) Place of Injury        |
| 10) Eligibility Status   | 31) Admitting Service       | 51) Operation Code         |
| 11) Beneficiary Class    | 32) Discharge Service       | 52) Dental ADA Codes       |
| 12) Medicare             | 33) Appt/Walk-In            | 53) Immunizations          |
| 13) Medicaid             | 34) Level of Service        | 54) Treatments Provided    |
| 14) Private Insurance    | 35) Eval&Management CPT     | 55) Lab Tests              |
| 15) Medicaid Plan Name   | 36) Length of Stay          | 56) Medications            |
| 16) Pvt Ins Plan Name    | 37) Primary Prov Name       | 57) CPT Code               |
| 17) Priv Ins Verified    | 38) Prim/Sec Prov Name      | 58) Exclude Inactive Pts   |
| 18) Desig Prim Care Prov | 39) Prim Prov Disc          | 59) Inactive Patients      |
| 19) EDC                  | 40) Prim/Sec Prov Disc      | 60) Excl Incomplete Visits |
| 20) Date EDC Determined  | 41) Prim Prov Affil         | 61) Operating Prov         |
| 21) Contraception Method |                             |                            |

After you have selected and defined the visit selection items, you will be returned to the item list. The items that you selected will be marked with an asterisk (\*). You may add or remove items at this point, if needed, by entering "S" (select) or "R" (remove). If you are finished making your selections, press "Q" to leave this screen and continue creating your report.

**Selecting the Report Type**

When using the VGEN option, you will need to select the type of report to be generated. You will be presented with the following choices:

- |   |                            |   |  |
|---|----------------------------|---|--|
| T | Total Count Only           | D | Detailed Visit Listing                       |
| S | Sub-counts and Total Count | F | Flat file of Area Database formatted records |
| C | Cohort/Template Save       |   |  |

The total count report prints only the total number of visits that match the selection criteria you chose as well as the total number of patients in that group. If you select this report type, no further actions are necessary beyond this step to generate the report.

The sub-counts and total count report lists the total number of matches as well as the subtotal of each different category of the sort variable selected; for example, if you sorted the report by sex, the number of visits for males and the number of visits for females in the group would be printed. Totals and sub-totals are included for both visits and patients. Skip to "Selecting a Sort Variable" for the next step for generating this report type.

The cohort/template save option saves in a template the patients that match your selection criteria. Only the total number of matching visits and the number of patients in that group are displayed. You can then use the template for generating custom reports with VGEN.

The detailed visit listing allows you to create a report that prints only the data items that you need sorted by the variable you select. If you have selected the detailed visit listing, read the sections below for instructions on selecting the print items and sort category. You may save this report logic for use later by responding “Y” and entering a report name at the appropriate prompts. These prompts appear after the selection of the sort variable.

The final output option, flat file of Area Database formatted records, allows you to capture the selected visit data in a file that is formatted for export to the Area Database. If you select this option, a message will display to the screen indicating the name for the file that will be created. The total number of visits in the selection process and the total number of visits that generated Area Database records will display. A detailed description of the file format is included in the Appendix (page 177). See your Site Manager if you need assistance with using this output type.

### Selecting Print Items

If you have selected the detailed visit listing report type, you will be presented with the following menu of data items that can be printed. Remember that you can print up to 132 characters if you have a printer capable of printing 132 character lines. Otherwise, your report may not exceed 80 characters. Choose the data items in the order that you would like them printed. For instructions on browsing and selecting items, refer to the previous section “Selecting Search Criteria.”

#### Print Item Menu

- |                             |                             |                          |
|-----------------------------|-----------------------------|--------------------------|
| 1) Name                     | 26) Visit Date              | 50) Primary Dx (POV)     |
| 2) Chart #                  | 27) Visit Date&Time         | 51) Diagnosis Prov Narr  |
| 3) Terminal Digit #         | 28) Time of Visit           | 52) Diagnosis ICD Narr   |
| 4) SSN                      | 29) Type (IHS,638,etc.)     | 53) Stage of Dx (POV)    |
| 5) Sex                      | 30) Service Category        | 54) Alcohol/Work Related |
| 6) Date of Birth            | 31) Visit Location          | 55) Cause of Dx (POV)    |
| 7) Age                      | 32) Service Unit of Patient | 56) Cause of Injury      |
| 8) Date of Death            | 33) Outside Location        | 57) Place of Injury      |
| 9) Community                | 34) Clinic Type             | 58) Operation Code       |
| 10) Tribe                   | 35) Admitting Service       | 59) Operation Prov Narr  |
| 11) Eligibility Status      | 36) Discharge Service       | 60) Operation ICD Narr   |
| 12) Beneficiary Class       | 37) Date of Discharge       | 61) Measurements         |
| 13) Medicare                | 38) Appt/Walk-In            | 62) Medications          |
| 14) Medicaid                | 39) Level of Service        | 63) Dental ADA Codes     |
| 15) Private Insurance       | 40) Eval&Management CPT     | 64) Labs and Results     |
| 16) Third Party Eligibility | 41) Length of Stay          | 65) Immunizations/Series |
| 17) Medicaid Plan Name      | 42) Amount Billed           | 66) Skin Tests/Readings  |
| 18) Pvt Ins Plan Name       | 43) Primary Prov Name       | 67) Treatments Provided  |
| 19) Priv Ins Verified       | 44) Prim/Sec Prov Name      | 68) Activity/Travel Time |
| 20) Desig Prim Care Prov    | 45) Prim Prov Disc          | 69) Education Topics     |
| 21) EDC                     | 46) Prim/Sec Prov Disc      | 70) Health Factors       |
| 22) Date EDC Determined     | 47) Prim Prov Affil         | 71) CPT Code             |
| 23) Contraception Method    | 48) Prim/Sec Prov Affil     | 72) Date Visit Exported  |
| 24) EDC Determination       | 49) Diagnosis Code          | 73) Operating Prov       |
| 25) Last Menstrual Period   |                             |                          |

## Selecting a Sort Category

If you are creating a detailed report listing or a sub-counts and total count report, you will be presented with the following menu to select a sort variable. If you do not choose a variable, the report will be sorted by Visit Date. To select a sort variable, follow the procedures outlined in the "Selecting Search Criteria" section. After you have selected a sort category, you have the option of printing each unique value of the sort criteria on a separate page.

### Sort Criteria Menu

- |                             |                             |                         |
|-----------------------------|-----------------------------|-------------------------|
| 1) Name                     | 15) Desig Prim Care Prov    | 29) Clinic Type         |
| 2) Chart #                  | 16) EDC                     | 30) Admitting Service   |
| 3) Terminal Digit #         | 17) Date EDC Determined     | 31) Discharge Service   |
| 4) Sex                      | 18) Contraception Method    | 32) Date of Discharge   |
| 5) Date of Birth            | 19) EDC Determination       | 33) Appt/Walk-In        |
| 6) Age                      | 20) Last Menstrual Period   | 34) Level of Service    |
| 7) Date of Death            | 21) Visit Date              | 35) Eval&Management CPT |
| 8) Community                | 22) Visit Date&Time         | 36) Length of Stay      |
| 9) Tribe                    | 23) Time of Visit           | 37) Primary Prov Name   |
| 10) Eligibility Status      | 24) Type (IHS,638,etc.)     | 38) Prim Prov Disc      |
| 11) Beneficiary Class       | 25) Service Category        | 39) Prim Prov Affil     |
| 12) Third Party Eligibility | 26) Visit Location          | 40) Primary Dx (POV)    |
| 13) Medicaid Plan Name      | 27) Service Unit of Patient | 41) Operating Prov      |
| 14) Pvt Ins Plan Name       | 28) Outside Location        |                         |

## Viewing the Report

For lengthy report outputs you will have the option of producing a printed report or displaying the report on the screen for browsing. If you choose to browse the output on the screen, remember that your report must be 80 characters or fewer in width. Use the following keys for browsing the on-screen output:

- + next screen
- previous screen
- Q quit
- ?? more actions

If you choose to generate a printed report, your report may include up to 132 characters in width. Note that any reports greater than 80 characters wide must be printed on a printer capable of producing 132 character lines or a printer set up for condensed print.

February 1997

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The following sample PCC Visit report is based on the criteria below:

**Visit Selection Criteria**

Encounter Date Range: SEP 01, 1994 to SEP 15, 1994

Visit Service Category: CHART REVIEW

Primary Provider: CURTIS,CLAYTON

**Print Field Selection**

Patient Chart # (2)

Visit Date (22)

Service Category (26)

Primary Provider (38)

Diagnosis Code (44)

Diagnosis Provider Narrative (45)

**Visits will be Sorted by:** Visit Date

---

---

Visit Dates: SEP 01, 1994 and SEP 15, 1994

HRN	DATE	SERV CAT	PROVIDER	PRIM DX	DX PROVIDER NARRATIVE
SE103111	09/09/94	CHART REVI	CURTIS,CLAYTON	278.0	MORBID OBESITY
SE100480	09/10/94	CHART REVI	CURTIS,CLAYTON	250.00	DM
SE103052	09/11/94	CHART REVI	CURTIS,CLAYTON	401.9	HTN

Total Visits: 3

Total Patients: 3

RUN TIME (H.M.S): 0.0.3

End of report. HIT RETURN:

---

---

---

**DEL Delete VGEN/PGEN Report Definition**

This option enables the user to delete a PCC Visit General Retrieval (VGEN) or Patient General Retrieval (PGEN) report definition. You will enter the name of the report you want to delete and then confirm that the report you specified is the one you want deleted. The report will be automatically deleted and is not retrievable.

A sample of the process is shown below.

---

```
REPORT NAME: MLJ INJURY REPORT JARRET,MARY L-APR 11, 1996@07:50:02
Are you sure you want to delete the MLJ-INJURY REPORT report definition? N// Y YES
Report Definition JARRET,MARY L-APR 11, 1996@07:50:02 deleted.
```

---

## RADM Readmissions within 30 Days of a Discharge

This report displays a list of patients who have had a new hospital admission within 30 days of a previous discharge. You will enter a beginning and ending date for the reporting period and specify whether the report is for one facility that you name or any facility. If you choose the report to include any facility, a patient who was discharged from the local facility and then admitted to a contract facility within 30 days would appear in the report. However, if you specified the report to include only the local facility, this patient would not appear in the report.

---



---

NAME	HRCN	ADM DATE	LOC	PROV	ICD	PROVIDER NARRATIVE
SELLS HOSPITAL/CLINIC <span style="float: right;">Page 1</span>						
READMISSIONS WITHIN 30 DAYS OF A DISCHARGE						
VISIT DATES: Jul 01, 1996 TO Aug 02, 1996						
<hr/>						
JONES, RAY	100228	7/3/96	SE	WALTERS, JO	681.10	CELLULITIS & ULCER
		7/17/96	SE	MARTIN, DON	V58.8	WOUND CARE DRESSING
					730.27	OSTEOMYELITIS R GRE
RUBBLE, MARIE	100538	7/17/96	SE	KINO, JAVIE	644.20	PREMATURE LABOR AT
		7/21/96	SE	WATERMAN, R	642.94	STATUS POST C SECTI
THATCHER, DALE	100877	7/14/96	SE	LORENZ, RUD	644.20	PREMATURE LABOR AT
					648.23	ANEMIA MODERATE
		7/21/96	PI	ALFREDO, L	648.21	ANEMIA, ESTIMATED BL
					663.31	NORMAL SPONTANEOUS
CARPENTER, DAVE	101111	7/18/96	SE	BURGMAN, SU	291.8	ALCOHOL WITHDRAWAL
					303.90	CHRONIC ALCOHOL ABU
					493.90	REACTIVE AIRWAY DIS
		7/21/96	GH	FILIPI, JU	291.8	ALCOHOL WITHDRAWAL
					303.90	ACUTE ALCOHOLISM
					493.90	REACTIVE AIRWAYS DI
					578.9	GASTROINTESTINAL BL
GREENJEANS, ALEXANDRA	100146	7/30/96	SE	BRADY, EILE	496.	EXACERBATION CHRONI
		8/3/96	SE	MOORE, RICH	493.90	ASTHMA
					496.	CHRONIC OBSTRUCTIVE
ADAMS, WALLY	100391	8/2/96	SE	MARTINEZ, L	250.40	DIABETES MELLITUS
					585.	END STAGE RENAL DIS
					691.8	ATOPIC DERMATITIS S
		8/7/96	LA	GRIFFITH, S	V58.4	WOUND INFECTION
					250.40	DIABETES MELLITUS
					585.	END STAGE RENAL DIS

---



---

---

## VST Display Single Visit for a Patient

Report options for obtaining data specific to a single visit by a selected patient have been grouped under the VST sub-menu. The following reports are available from the Patient Single Visit menu.

```
*****
**      PCC Management Reports      **
**      Patient Single Visit Menu   **
*****
```

Version 3.0

SELLS HOSPITAL/CLINIC

```
DISP  Display Data for a Specific Patient Visit
LCV   Display Data for Patient's Last Visit to a Clinic
LVST  Display Data for a Patient's Last Visit
```

---

## DISP Display Data for a Specific Patient Visit

This option displays all visit-related data for a specific patient's visit. You will enter the Patient's Name and the Visit Date. If more than one visit exists on the same day, you will be asked to choose the visit you want displayed.

The Visit File displays first, followed by all visit-related data files corresponding to the visit selected; for example, Providers, POVs, and Measurements.

---

```

-----          VISIT FILE          -----
VISIT/ADMIT DATE&TIME: MAR 30, 1994@13:23
  DATE VISIT CREATED: MAR 30, 1994      TYPE: IHS
  PATIENT NAME: JOHNSON, MARY
  LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
  SERVICE CATEGORY: AMBULATORY          CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 7              DATE LAST MODIFIED: JUN 15, 1994
  DATE VISIT EXPORTED: JUN 26, 1994

-----          V MEASUREMENT        -----
TYPE: BP                                PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            VALUE: 140/90

-----          V PROVIDER            -----
PROVIDER: SHORR, GREG                   PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100025
PROVIDER: MARTIN, GRETCHEN              PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101GM

-----          V POV                  -----
POV: 401.9                              PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23
  PROVIDER NARRATIVE: HYPERTENSION BP UNDER CONTROL THIS VISIT
ICD NARRATIVE (c): HYPERTENSION NOS
POV: 250.00                             PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM

-----          V EXAM                 -----
EXAM: BREAST EXAM                       PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 06
EXAM: RECTAL EXAM
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 14

```

---

---

## LCV Display Data for Patient's Last Visit to a Clinic

The LCV report option is nearly identical to the LVST report option described on the following page. The only difference between the reports is that the LCV report displays visit-related data for a patient's last visit to a selected **clinic**. You will enter the Patient's Name and specify the Clinic. All visit-related data will be printed in the report.

The sample report below was generated for Art Greenjeans' last visit to the General Clinic.

---

```

VISIT IEN: 23251
-----
VISIT FILE
-----
VISIT/ADMIT DATE&TIME: JAN 29, 1990@09:57
  DATE VISIT CREATED: MAR 16, 1990      TYPE: IHS
  PATIENT NAME: GREENJEANS,ART          LOC. OF ENCOUNTER: SELLS
HOSPITAL/CLINIC
  SERVICE CATEGORY: AMBULATORY          CLINIC: GENERAL
  DEPENDENT ENTRY COUNT: 6

-----
V MEASUREMENT
-----
TYPE: HT                                PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57           VALUE: 56.25
  PERCENTILE: 99.9

TYPE: WT                                PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57           VALUE: 92.25
  PERCENTILE: 99.9

TYPE: VU                                PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57           VALUE: 15/20

-----
V PROVIDER
-----
PROVIDER: REGISTERED NURSE,IHS          PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101999
PROVIDER: PHYSICIAN,VOLUNTEER          PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 600999

-----
V POV
-----
POV: V70.9                              PATIENT NAME: GREENJEANS,ART
  VISIT: JAN 29, 1990@09:57            PROVIDER NARRATIVE: PHYSICAL EXAM
  FIRST/REVISIT: REVISIT                PRIMARY/SECONDARY: PRIMARY
ICD NARRATIVE (c): GENERAL MEDICAL EXAM NOS

```

---

---

## LVST Display Data for a Patient's Last Visit

This option allows you to view all visit-related data for the patient's last visit. The Visit File displays first followed by each visit-related data file; for example, Providers, POVs, and Measurements.

---

```

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: MAR 30, 1994@13:23
  DATE VISIT CREATED: MAR 30, 1994      TYPE: IHS
  PATIENT NAME: JOHNSON, MARY
  LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
  SERVICE CATEGORY: AMBULATORY          CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 7              DATE LAST MODIFIED: JUN 15, 1994
  DATE VISIT EXPORTED: JUN 26, 1994

----- V MEASUREMENT -----
TYPE: BP                                PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            VALUE: 140/90

----- V PROVIDER -----
PROVIDER: SHORR, GREG                   PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100025
PROVIDER: MARTIN, GRETCHEN              PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101GM

----- V POV -----
POV: 401.9                               PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23
  PROVIDER NARRATIVE: HYPERTENSION BP UNDER CONTROL THIS VISIT
ICD NARRATIVE (c): HYPERTENSION NOS
POV: 250.00                               PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23            PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM

----- V EXAM -----
EXAM: BREAST EXAM                       PATIENT NAME: JOHNSON, MARY
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 06
EXAM: RECTAL EXAM
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 14

```

---

## DM Diabetes Program QA Audit

```
*****  
**      PCC Management Reports      **  
**      Diabetes Audit Report Menu  **  
*****  
Version 3.0
```

SELLS HOSPITAL/CLINIC

```
DM      DM Audit Report  
MED     Create Medication Taxonomies (INSUL,ORAL,ACEI)  
CHOL    Add/Edit CHOLESTEROL Lab Test Taxonomy  
CREA    Add/Edit CREATININE Lab Test Taxonomy  
GLUC    Add/Edit GLUCOSE Tests Lab Test Taxonomy  
HGB     Add/Edit HGB A1C Lab Test Taxonomy  
PAP     Add/Edit PAP SMEAR Lab Test Taxonomy  
TRIG    Add/Edit TRIGLYCERIDE Lab Test Taxonomy  
UPRO    Add/Edit URINE PROTEIN Lab Test Taxonomy  
URIN    Add/Edit Urinalysis Lab Test Taxonomy
```

This menu consists of options that facilitate the set-up and running of the official IHS Diabetes Audit Report. The report is part of the IHS Diabetes Management System designed to facilitate individual diabetes patient care and diabetes program management. Details on set-up for the Audit Report are described in the PCC Diabetes Management System (version 3.0) user's manual. All options for adding or editing taxonomies are used during the initial set-up process only.

Features of the Diabetes Management System include:

- A Diabetes Register using the PCC Case Management System
- A Diabetes Flowsheet included on the PCC Health Summary
- Monitoring/prompting of important care items on the Health Summary
- Standard nomenclature for recording diabetes exams and education on PCC forms
- An automated Diabetes Program Audit Report
- Case Management System report options
- Access to all PCC clinical data

The system capitalizes on data contained in the PCC and minimizes redundant data entry on the part of local Diabetes Coordinators. The system's features, including instructions for their implementation and full utilization, are described in detail in the PCC Diabetes Management System (version 3.0) manual.

The Diabetes Management System was developed jointly by the PCC Development Team in Tucson, the IHS Diabetes Program, and health-care providers involved in direct patient care.

**Since the DM Audit Report is generated from the PCC Database, clinical information must be entered into the PCC or the report does not recognize that the clinical event occurred.**

Descriptions of each item retrieved for printout on the audit report are provided in detail below.

### **Demographic Data**

**Audit Date:** The date the report was generated.

**Report Dates:** The date range specified by the person generating the report.

**Chart Number:** Chart number for the patient from the facility for which the report was generated.

**Report Generated by:** The person who ran the report.

**Service Unit:** The Service Unit of the facility for which the report was run.

**Area:** The IHS Area in which the facility resides.

**Date of Birth:** The patient's date of birth

**Facility:** The facility for which the report was run.

**Sex:** The sex of the patient.

**Age:** The patient's age is calculated as of the report generation date.

### **Clinical Data**

**Tobacco Use:** This is retrieved from the Health Status file, the PCC Problem List, or the Purpose of Visit file. The system first looks for the last occurrence of any of the following in the Health Status file (the Health Status file stores the last of each of a patient's health factors).

- Current Smokeless
- Current Smoker
- Non-Tobacco User
- Previous Smokeless
- Previous Smoker

If tobacco use is not documented in the Health Status file, the system scans the PCC Problem List for a diagnosis of Tobacco Use (305.1-305.13). If no Problem List entry is found, the system scans all POVs during the indicated time frame for a diagnosis of tobacco use (305.1-305.13). If tobacco is found, the system includes it in the printout. If a problem or POV is found, the Provider Narrative is also printed. If no evidence of tobacco use is found, the message UNDOCUMENTED will be printed.

**Date of Onset of Diabetes from CMS/Problem List:** The system determines the date of onset of diabetes based on the following:

1. The system checks the official Diabetes Register. If the patient exists in the register, the date of onset is obtained from the Date of Onset field in the DM Diagnoses for the client file.
2. The system scans the Problem List for a problem diagnosis of 250.00-250.93. If one is found and the date of onset has been recorded, the system uses that date.

3. If no date is found, the message DATE OF ONSET NOT RECORDED will be printed.

**Date of Earliest Diabetes Diagnosis from PCC:** The system utilizes the ICD9 diagnostic codes 250.00-250.93 to determine the earliest purpose of visit for diabetes that has been entered into the purpose of visit file. Note that this date may not be the same as the date of onset.

**Height:** The last height on record is printed. Note that this height may have been recorded after the audit ending date.

**Weight:** The last weight recorded on a non-prenatal visit is printed.

**BMI:** The body mass index, a commonly used index of obesity in populations, is calculated from the patient's height and weight data and printed in the report. The value is a ratio of patient's weight in kilograms to patient's height in meters<sup>2</sup>.

**Weight, Blood Pressure, and Blood Sugar Recorded 75% of Visits:** The system searches all visits to determine if at least one purpose of visit contains a diagnosis of diabetes (ICD code 250.00-250.93) during the indicated date range. If diabetes is found, the report prints the percentage of diabetic-related visits during which the indicated reading or test result was obtained.

**Last 3 Blood Pressures and Last 3 Blood Sugars:** The last 3 blood pressures and last 3 blood sugars during the indicated date range will be printed, if available. Blood pressures or blood sugars taken in the emergency room are not included in the report. The lab tests used when determining whether a blood sugar was done are those indicated by you during the initial set-up procedures.

**HTN Documented:** The system first checks to see if there is a hypertension diagnosis (ICD Code range 401.0-405.99) on the PCC Problem List. If not, the system checks to see if the patient had a purpose of visit where they received a diagnosis of hypertension (ICD code range 401.0-405.99) in the 5 years prior to the end of the indicated date range.

**Last Hgb A1c/GHb:** The system finds the last instance of this test during the specified date range. Note that there is a space on the report adjacent to the test result that can have the normal range for this test entered.

### Examinations

**Diabetic Foot Exam, Complete:** Indicates whether the patient had a diabetic foot exam recorded during report time frame.

**Diabetic Eye Exam:** Indicates whether the patient had a diabetic eye exam recorded during the report time frame.

**Rectal Exam:** Only reviewed if the patient is older than 40 years of age. Indicates whether the patient had a rectal exam during the report time frame.

**Pap Smear:** Indicates whether a FEMALE patient had a pap smear during the report time frame.

**Breast Exam:** Indicates whether a FEMALE patient had a breast exam during the report time frame.

**Mammography:** Indicates whether a FEMALE patient ever had a mammogram. The date of the last mammogram is reported and its accordance with the following ACS guidelines is noted:

- Ages 40-49: mammogram within the past 24 months
- Ages 50 and up: mammogram within the past 12 months

### Education

The current PCC list of Diabetes Education Topics includes the following items:

- DM-C Complications
- DM-N Nutrition
- DM-EX Exercise
- DM-GI General Information

The previous list of Diabetes Education Topics that was in effect prior to October 1993 is no longer recommended for use, although the audit program continues to accept them.

### Therapy

The system will determine whether the patient received insulin, an oral hypoglycemic, or both during the 4 months prior to the end of the indicated time frame. If there is no evidence of drugs prescribed, the system displays DIET ALONE.

**Ace Inhibitor Use.** The report indicates whether the patient received an ace inhibitor during the 4 months prior to the end of the audit time frame. If not, the report displays the message DOES NOT CURRENTLY USE/UNDETERMINED. The medicines audited when determining ace inhibitor use are those specified during the initial setup procedures described on pages 26 to 28.

### Immunizations

**Flu Vaccine:** Indicates if a vaccine was given during the report time frame.

**Pneumovax:** Indicates if ever given.

**Td:** Indicates if given during the past 10 years.

**TB Status:** Retrieved from the Health Status file. The TB Status Health Factors are:

- TB - Tx Complete
- TB - Tx Incomplete
- TB - Tx Unknown
- TB - Tx Untreated

**PPD:** Date of last PPD and result.

---

**PPD Status Code:** A patient's PPD status will be indicated by one or more of the following messages:

- PPD + Treatment Complete (based on health factor)
- PPD + Not Treated or Unknown Treatment
- PPD – Up-to-Date (placed in or after DX)
- PPD – Placed Before Date of DX
- PPD – Date of DX Unknown
- PPD Status Unknown

### Laboratory Data

**EKG:** EKG results are not available through the PCC. On the basis of a chart review, the reviewer must indicate if an EKG was ever given.

**Urinalysis:** If the patient had a urine protein during the indicated date range, the report will indicate that a urinalysis occurred.

**Proteinuria:** If the last urine protein during the indicated date range was 1+, 2+, or 3+, then proteinuria is indicated.

**Microalbuminuria.** For those without evidence of proteinuria, indicates whether a test for microalbuminuria was positive, negative, or not performed.

**Creatinine:** Indicates the result of the last creatinine during the indicated date range. If the patient has a Purpose of Visit code that indicates dialysis, the message ON DIALYSIS will be printed.

**Cholesterol:** The last cholesterol level during the indicated date range is printed.

**Triglycerides:** The last triglyceride level during the indicated date range is printed.

### Sample Audit Reports

The following three pages contain sample audit reports. An individual report is presented first, followed by a cumulative report.

IHS DIABETES PROGRAM QUALITY ASSURANCE AUDIT

AUDIT DATE: APR 30, 1996      REPORT DATES: Fiscal Year 1995  
CHART NUMBER: 256498      REPORT GENERATED BY: JOHNSON, MARY  
SERVICE UNIT: SELLS      AREA: TUCSON  
DATE OF BIRTH: JAN 01, 1933      FACILITY: SELLS HOSPITAL/CLINIC  
NAME: THATCHER, BECKY      SEX: F      AGE: 62

TOBACCO USE: YES, USES TOBACCO  
DATE of Onset from [CMS]: JAN 1959  
DATE of Earliest Diabetes Diagnosis from PCC: JAN 01, 1960

Vital Statistics

LAST HEIGHT: 5 feet .3 inches  
WEIGHT recorded 75% of diabetes visits: NO - 31%  
LAST WEIGHT: 144.0925 lbs      SEP 25, 1995      BMI: 8.5  
HTN documented (DX): YES  
BLOOD PRESSURE taken 75% of diabetes visits: NO - 38%  
Last 3 BLOOD PRESSURES (excluding ER Visits):  
120/90 mm HG      SEP 25, 1995  
120/80 mm HG      MAY 24, 1995  
120/90 mm HG      DEC 22, 1994

BLOOD SUGAR recorded 75% of diabetes visits: NO - 50%

Last 3 BLOOD SUGARS : GLUCOSE - RANDOM - 250      SEP 25, 1995  
GLUCOSE - RANDOM - 200      SEP 01, 1995  
GLUCOSE - RANDOM - 20      JUN 29, 1995  
LAST Hgb Alc/GHb : -      (normal range: \_\_\_\_\_)

Examinations (during indicated date range)

DIABETIC FOOT EXAM: NO  
DIABETIC EYE EXAM: YES  
DENTAL EXAM: YES  
RECTAL EXAM (if >40 yrs old): NO  
Females: PAP SMEAR: NO  
BREAST EXAM: YES  
Females 40&over: MAMMOGRAM EVER (before end of time frame): YES  
Last Done: 03/25/93      Per ACS Guidelines: NO

Education (during indicated date range)

DIET INSTRUCTION: NO  
EXERCISE INSTRUCTION: NO  
Other GENERAL DM EDUCATION: NO

Therapy (during indicated date range): Diet Alone

ACE INHIBITOR Use (on Sep 30, 1995): Does not currently use/undetermined  
Immunizations

FLU VACCINE during indicated date range: YES - SEP 01, 1995  
PNEUMOVAX ever: NO  
Td in past 10 years: YES  
Last PPD Reading: 1mm;NEGATIVE - NOV 22, 1994  
TB Treatment Status (Health Factor): TB - TX COMPLETE  
PPD Status Code: PPD -, up-to-date (placed after dm dx) (3)

Laboratory data (during indicated date range)

EKG ever in chart: YES  
URINALYSIS: NO  
Proteinuria:  
CREATININE: YES - 80  
CHOLESTEROL: NO  
TRIGLYCERIDES: YES - ?

Local Item: \_\_\_\_\_

IHS DIABETES QA AUDIT FOR Fiscal Year 1995  
CUMULATIVE REPORT

Total Number of Patients Audited: 175

DATE: APR 30, 1996                      REVIEWER: JOHNSON, MARY  
SERVICE UNIT: SELLS                      AREA: TUCSON  
FACILITY: SELLS HOSPITAL/CLINIC

	Percent Compliance
BASELINE DATA	
Female	68%
Age	
<15 yrs	0%
15-44 yrs	18%
45-64 yrs	51%
65 yrs and older	31%
Diabetes Treatment - diet	58%
insulin	21%
oral	12%
both	9%
ACE INHIBITOR - currently uses	12%
- does not currently use	
or undetermined	88%
Flowsheet current	72%
Tobacco	
Tobacco used	32%
Tobacco not used	52%
Tobacco used in past	4%
Tobacco use not documented	12%
Duration of Diabetes	
Less than 10 years	26%
10 years or more	63%
Date of Onset not recorded	11%
Overwt/Obese	
*(height may be old)	
Overweight (BMI >27.7 or >27.2)	66%
Obese (BMI >31.0 or >32.2)	39%
BMI could not be calculated	14%
Height recorded	86%
PERFORMED AT LEAST 75% OF VISITS	
Weight	76%
Blood Pressure	94%
Normotensive	42%
Controlled HTN	23%
Uncontrolled BP	24%
Severe HTN	3%
Undocumented HTN control	8%
Blood Sugar	83%
Control Level acceptable	56%
Control Level fair	14%
Control Level Poor	21%
Control Level Very Poor	5%
Control Level Undocumented	4%

Facility: SELLS HOSPITAL/CLINIC

## Percent Compliance

EXAMS - Yearly	
Diabetic Foot Exam, Complete	67%
Diabetic Eye Exam	62%
Dental Exam	48%
Rectal Exam (>40 yrs)	31%
PAP smear	89%
Breast exam	92%
Mammogram ever	54%
Mammogram per ACS guidelines	50%
DIABETES RELATED EDUCATION - Yearly	
Any Diet Instruction	64%
Exercise Instruction	60%
Any Diabetes Education	76%
IMMUNIZATIONS	
Flu Vaccine - yearly	21%
Pneumovax - once	67%
Tetanus/Diphtheria (q 10 yrs)	46%
LABORATORY EXAMS	
EKG - Once	43%
Urinalysis - yearly	78%
Proteinuria	54%
Creatinine - yearly	66%
Creatinine > 2.0	44%
Cholesterol - yearly	78%
Cholesterol > 240 mg/dl	51%
Triglyceride - yearly	65%
PPD STATUS	
PPD +, Treatment Complete	21%
PPD +, Not treated or unknown treatment	7%
PPD -, Up-to-date (ie, placed on or after diagnosis date)	15%
PPD -, before DM diagnosis	18%
PPD -, date of DM diagnosis unknown	25%
PPD status unknown	14%
TB STATUS (HEALTH FACTOR)	
TB - TX COMPLETE	13%
TB - TX INCOMPLETE	33%
TB - TX UNKNOWN	77%
TB - TX UNTREATED	66%
TB - Health Factor not recorded	5%

Local item:

---

## Generating a Patient Cohort for the Audit Report

You may utilize the PCC QA Audit Report option by entering a list of individual patient identifiers (names or chart numbers) or entering the name of a template, or cohort, of patients that you have saved from a previous retrieval. Three methods for generating and saving a cohort for use in the Audit Report are described below.

### 1 Using Your Entire DM Register as Your Audit Cohort

Since the automated audit process takes less than a minute per patient, you may wish to audit all active patients in your Diabetes Register. To do so, you must first be in the Case Management System where your Diabetes Register data resides. In Case Management, select the Report Generation menu option. Next, enter the name of your Diabetes Register. Then select the Patient and Statistical Reports menu option.

When prompted for a report type, select "DIAGNOSES." When prompted for a sort order, select "PATIENT." Respond "NO" when prompted for a particular patient and "NO" when prompted for another sorting attribute. When asked for a patient or statistical report, respond by typing "P," for patient.

When prompted to "Store Report Result as a Search Template," respond "YES." You will then see "Search Template:" which is prompting you to name your template. Enter "DM REGISTER PTS" followed by the current date; for example, DM REGISTER PTS 10/12/95. The computer then asks, "Are you adding DM REGISTER PTS 10/12/95 as a new sort template?" Respond "YES."

At the prompt for Device, you may enter "HOME" or you may queue the report to run at a later time. The system will then select and store in your template all active patients in your register for use in the QA Audit Report.

After creating this template, or cohort, you may proceed to run the QA Audit Report as instructed previously in this manual.

### 2 Generating a Random Sample as Your Audit Cohort

At sites with a large Diabetes Register, you may wish to use a random sample of your active diabetes patients when running the PCC QA Audit Report. To accomplish this, first perform all of the steps described in step 1 above to create a template or cohort containing active patients in your register.

Next, select Q-Man from the Case Management System main menu. In Q-Man, select the SEARCH mode and use LIVING PATIENTS as your subject. When prompted for an Attribute of Living Patients, enter the left square bracket ( [ ) followed immediately by the name of your template; for example, [DM REGISTER PTS 10/12/95. Q-Man will retrieve your cohort and present you with four options. Select option 3 to generate a random sample of your cohort. You will then be asked whether you want a specific number of entries in your sample or a percentage of your cohort. Select 1 and then enter the number of patients you want to have in your sample.

When prompted for another Q-Man attribute, press Return or Enter. You will then be given several retrieval options. Select 4–Store Results in a FM Search Template. At the template name prompt, enter “SAMPLE OF DM PTS” followed by the date; for example, SAMPLE OF DM PTS 10/12/95. Respond “YES” when prompted “Are you adding this new template?” Bypass the description prompt by pressing Return or Enter. Respond "NO" at the “Run this job in the background?” prompt. Q-Man generates your sample cohort, which can then be used in the PCC DM QA Audit Report.

### **3 Generating an Audit Sample When You Do Not Have a Diabetes Register**

If you have not established your Diabetes Register but wish to make use of the PCC DM QA Audit Report, you may build a cohort or sample cohort using Q-Man only. With Living Patients as your Q-Man subject, you can use one or more Q-Man attributes to find your diabetic population and save them in a template to be used in the Audit Report. This process is described in detail in the Diabetes Management manual in the section entitled "Entering Patients in the Register from a Q-Man Search of PCC Files."

After using this procedure to create and name a template of diabetics, that template can be used in the Audit Report. You may also use your template of diabetics as a Q-Man attribute to generate a random sample as described in step 2 above.



# APC APC Reports

This set of reports examines PCC visits and counts all APC visits in a given time frame for the facility that you select. The following reports are available:

```

*****
**      PCC Management Reports      **
**              APC Reports              **
*****
Version 3.0

SELLS HOSPITAL/CLINIC

1A      PCC-Ambulatory Patient Care Report 1A
DATE    APC Visit Counts by Date Of Visit
CLN     APC Visit Counts by Clinic
DISC    APC Visit Counts by Provider Discipline
APRV    APC Visit Counts by Individual Provider
DX      APC Visit Counts by Primary Diagnosis (APC CODE)
LOC     APC Visit Counts by Location of Service
AVCL    Average Number of Visits by Day of Week and Clinic
AVCS    Average Number of Visits by Day/Clinic ALL Service
AVD     Average Number of APC Visits per Day
CYV     Calendar Year First and Revisit Summary
DXC     APC Visit Counts by APC Major Diagnosis Category
NOEX    List APC-1A Visits Not Exported

```

Entry of all data into the PCC includes a designation of Location of Visit, Visit Type, and Service Category.

Location of Visit is the facility where the visit occurred (e.g., Crownpoint Hospital, Yakima Health Center, Home, San Simon School).

Visit Types include:

- IHS
- Contract
- Tribal
- Other
- Program
- VA

Service Categories include:

- Ambulatory
- Hospitalization
- In-Hospital Care
- Chart Review
- Telecommunications
- Not Found
- Day Surgery
- Observation
- Event (Historical)
- Nursing Home Care

These three visit attributes, plus the Clinic Type designation for outpatient clinic visits, determine whether a visit is an official APC visit for inclusion in the IHS data system. The criteria for inclusion are listed below. Data displayed on this set of APC Reports from PCC Files should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for Service Unit management purposes, a similar set of reports containing additional data, such as Not Found Visits, CHN Home Visits, and Telephone Calls, is a subset of the PCC Ambulatory Visit Counts, described in the next section of this manual.

**To be considered an APC visit, a visit MUST meet the following criteria:**

1. Fall within the date range specified.
2. Have other medical data linked to the visit record.
3. Have a Service Category of:
  - Ambulatory
  - Day Surgery
  - Observation
  - Nursing Home

EXCLUDES : Chart Review, Hospitalization, Not Found, In-Hospital, and Event

4. Have a Visit Type of:

- IHS
- 638 Program
- Tribal
- Other

5. Have a primary Purpose of Visit (POV cannot be an uncoded DX .9999).
6. Have a valid location.
7. Have a valid primary provider.

EXCLUDES: A Primary Provider Discipline of 13 (CHN) or 32 (CHR) AND a location of visit other than an IHS facility (code >49).

8. Have a valid clinic code.

EXCLUDES:

- Mail
- Telephone Call
- Chart Review
- Follow-up Letter
- Radio Call
- Dental
- Education Class
- Employee Health

You must enter the visit date range for use in calculating the number of visits and select whether visits for all locations or one location are to be included.

---

## 1A PCC-Ambulatory Patient Care Report 1A

This report generates from PCC files and is similar to the 1A report generated by the APC System at the Data Center in Albuquerque. Your facility should run this report on a quarterly basis to verify that all APC visits have been exported properly to the Data Center. If your site is new to PCC and the APC export process, this report should be run after every export until all export problems have been resolved.

The report displays FY-to-date APC visit counts by month of service. You will specify the fiscal year and the facility for the report. Totals generate for each month as well as for each provider discipline. Percentage totals display for each discipline. Total primary care provider visits will also subtotal for each month.

Primary Care Providers are primary providers with one of the following discipline codes:

00 - Physician	44 - Physician (Tribal)
11 - Physician Assistant	70-90 - Physician Specialists
16 - Pediatric Nurse Practitioner	17 - Nurse Midwife
18 - Contract Physician	21 - Nurse Practitioner
25 - Contract Podiatrist	33 - Podiatrist
41 - Contract OB/Gyn	

AREA: 00 TUCSON PCC-AMBULATORY PATIENT CARE REPORT 1A DEC 07, 1989 Page 1  
 S.U.: 01 SELLS TUCSON FISCAL YEAR 1987  
 FAC.: 000101 SELLS HOSPITAL/CLINIC

AMBULATORY CARE VISITS TO SERVICE LOCATION BY PRIMARY PROVIDER AND MONTH OF SERVICE

PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT
PHYSICIAN*	505	47.6	38	37	39	46	43	37	43	36	32	37	57	60
REGISTERED NURSE	29	2.7	2	1	2	4	4	2	4	1	1	3	2	3
LICENSED PRACTICAL OPTOMETRIST	12	1.1	0	1	3	4	2	0	0	1	1	0	0	0
PHARMACIST	18	1.7	0	2	1	2	2	3	3	1	0	0	0	4
PHYSICAL THERAPIST	116	10.9	13	10	6	10	15	9	8	8	10	8	9	10
PHYSICIAN ASSISTANT*	17	1.6	4	3	2	2	2	2	1	0	0	0	0	1
CHN/AIDES	48	4.4	4	5	3	7	5	3	5	1	6	1	3	5
OTHER	6	.6	0	0	0	0	1	1	0	0	0	2	1	1
NURSE MIDWIFE	19	1.7	7	3	0	.5	2	0	1	0	0	1	1	0
MENTAL HEALTH	37	3.5	4	1	5	3	3	5	2	6	1	1	4	2
MEDICAL STUDENT	2	.2	0	0	0	0	0	0	0	1	1	4	0	0
NURSE PRACTITIONER*	5	.5	0	0	0	0	0	1	0	0	0	0	3	1
NURSE ASSISTANT	12	1.1	1	0	1	3	3	0	0	1	1	3	0	2
LABORATORY TECHNIC	5	.5	0	0	1	0	0	1	0	1	1	1	1	0
DIETICIAN	5	.5	1	0	1	1	0	0	1	1	0	0	0	0
PODIATRIST*	1	.1	0	0	0	1	1	0	0	0	0	0	0	0
DENTIST	8	.8	1	1	1	1	1	1	0	2	0	0	0	1
INTERNAL MEDICINE*	8	.8	2	0	0	6	1	1	0	1	2	0	0	0
OB/GYN*	111	10.5	9	2	10	0	6	10	11	13	10	4	4	5
PEDIATRICIAN*	6	.6	0	9	0	3	0	1	0	1	1	0	0	0
SURGEON*	69	6.5	2	0	7	0	3	6	8	5	9	4	4	5
OPHTHALMOLOGIST*	8	.8	0	2	1	0	0	1	1	1	0	0	0	3
FAMILY PRACTICE*	11	1.0	0	0	0	0	0	1	1	0	0	2	2	4
NEUROLOGIST*	1	.1	0	0	0	0	0	0	0	0	1	0	0	0
NEUROLOGIST*	1	.1	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1060	100.0	88	81	82	124	97	80	91	80	77	62	91	1070
TOTAL PRIMARY PVDR	817	77.1	59	61	67	96	66	62	72	66	61	46	74	87

21 visits were not exported because of missing or invalid data. To see a list of these visits so that they may be resubmitted, use the option called 'List APC-1A Visits Not Exported.'

There were 138 instances of 2 or more visits by a patient to the same clinic on the same day. These 138 will not be counted in the report produced at the Data Center, but are counted in the report above. This accounts for a total of 159 visits that will be counted in this report but not in the 1A report from the Data Center.

---

## DATE    APC Visit Counts by Date of Visit

This report generates a count of visits by Date of Visit for a specified date range. The visits included are those that would be exported to the APC System.

---

```
*****
* SAN XAVIER HEALTH CENTER                                FEB 7,1995  Page 1 *
*                NUMBER OF APC VISITS BY DATE OF VISIT  *
*                LOCATION OF VISITS:  SAN XAVIER HEALTH CENTER *
*                REPORT DATE:  SEP 01, 1994 TO SEP 5, 1994 *
*****
```

DATE OF VISIT	DAY OF WEEK	# VISITS
SEP 01, 1994	MONDAY	104
SEP 02, 1994	TUESDAY	81
SEP 03, 1994	WEDNESDAY	92
SEP 04, 1994	THURSDAY	71
SEP 05, 1994	FRIDAY	91
		-----
	Total:	439

---

---

## CLN APC Visit Counts by Clinic Type

This report generates a count of visits by Clinic Type for a specified date range. The visits included are those that would be exported to the APC System.

---

```

*****
* SAN XAVIER HEALTH CENTER                                FEB 7,1995 Page 1 *
*                NUMBER OF APC VISITS BY CLINIC TYPE      *
*                LOCATION OF VISITS:  SAN XAVIER HEALTH CENTER *
*                REPORT DATE:  SEP 01, 1994 TO  SEP 02, 1994 *
*****
  
```

TYPE OF CLINIC	CLINIC CODE	# VISITS
DIABETIC	06	12
EMERGENCY MEDICINE	30	60
OTHER	25	8
PODIATRY	65	8
WELL CHILD	24	12
		-----
	Total:	100

---

---

## DISC APC Visit Counts by Provider Discipline

This report counts the number of visits by Provider Discipline for a specified date range. You may specify totals for primary provider only or for all providers. The visits included are those that meet the definition of an APC visit.

---

```
*****
* SAN XAVIER HEALTH CENTER                      FEB 7,1995  Page 1  *
*
*          NUMBER OF APC VISITS BY ALL PROVIDER DISCIPLINES      *
*          LOCATION OF VISITS:  SAN XAVIER HEALTH CENTER          *
*          REPORT DATE:  SEP 01, 1994 TO SEP 02, 1994            *
*****
```

PROVIDER DISCIPLINE	DISCIPLINE CODE	# VISITS
CHN/AIDES	13	5
DENTIST	52	7
INTERNAL MEDICINE	71	1
LICENSED PRACTICAL NURSE	05	12
NURSE ASSISTANT	22	7
NURSE MIDWIFE	17	1
NURSE PRACTITIONER	21	4
NUTRITIONIST	07	2
OPHTHALMOLOGIST	79	1
OPTOMETRIST	08	1
PHARMACIST	09	13
PHARMACY PRACTITIONER	30	2
PHYSICIAN	00	36
PHYSICIAN ASSISTANT	11	3
REGISTERED NURSE	01	12
		-----
	Total:	107

---

**APRV APC Visit Counts by Individual Provider**

This report counts visits by individual provider for a specified date range. You may choose to list primary providers only or all providers. The visits included are those that meet the definition of an APC visit.

```
*****
* SAN XAVIER HEALTH CENTER                                FEB 7,1995 Page 1 *
*
*          NUMBER OF APC VISITS BY ALL PROVIDERS OF SERVICE *
*          LOCATION OF VISITS:  SAN XAVIER HEALTH CENTER   *
*          REPORT DATE:  SEP 01, 1994 TO SEP 02, 1994     *
*****
```

PROVIDER OF SERVICE	DISCIPLINE OF PROV	# VISITS
BLACK, HAROLD C	DENTIST	2
BODE, AMY	PHYSICIAN	1
COMMUNITY HEALTH NURSE, IH	CHN/AIDES	3
DENTAL COSTEP	DENTIST	1
DENTIST, IHS	DENTIST	4
DODGE, FRANK	PHARMACIST	4
ENOS, SUSIE	REGISTERED NURSE	1
FOLSON, MALINDA	LICENSED PRACTICAL N	3
GONZALES, EVELYN	NURSE PRACTITIONER	4
INTERNIST, IHS	INTERNAL MEDICINE	1
JONES, DELPHINE	NURSE ASSISTANT	1
JOSE, MARY	LICENSED PRACTICAL N	6
LICENSED PRACTICAL NURSE,	LICENSED PRACTICAL N	1
LIVINGSTON, ROBERT	PHYSICIAN	3
LOGAN, DAVID	PHYSICIAN	1
LOPEZ, FRANCES	REGISTERED NURSE	2
MARFIN, TONY	PHYSICIAN	2
MARTIN, GRETCHEN	REGISTERED NURSE	4
MCDONALD, FRED	PHYSICIAN	1
MCGHEE, ROGER	PHARMACIST	3
		-----
	Total:	107

---

**DX APC Visit Counts by Primary Diagnosis (APC Code)**


---

This report counts visits by primary diagnosis for a specified date range. The visits included are those that meet the definition of an APC visit.

```
*****
* SELLS HOSPITAL/CLINIC APR 05, 1996 Page 1 *
*
* NUMBER OF APC VISITS BY PRIMARY DX (APC CODE) *
*
* LOCATION OF VISITS: ALL *
*
* REPORT DATE: JAN 01, 1995 TO DEC 30, 1995 *
*
*****
```

APC DX NARRATIVE	APC DX CODE	# VISITS
ACUTE OTITIS MEDIA	250	1
ADVERSE EFFECT OF MEDICIN	770	2
ADVERSE EFFECTS	791	1
ASSESSMENT OF SYMPTOMS	810	1
CHILDHOOD BEHAVIORAL DISO	170	4
DIABETES MELLITUS	080	38
ENVIRONMENTAL PROBLEM	826	1
FAMILY PLANNING	495	2
FEVER	806	7
FOLLOWUP CARE	820	1
FRACTURE	701	1
HYPERTENSIVE DISEASE	283	1
INFLUENZA	303	1
LACERATION	730	1
MENTAL DISORDER	175	17
NEUROSIS	130	1
OTHER PROBLEMS	827	26
PHYSICAL EXAMINATION	821	4
PSYCHOSIS	125	1
PULMONARY TUBERCULOSIS	005	1
RESPIRATORY ALLERGY	305	10
SOCIO-ECONOMIC PROBLEM	825	6
TUBERCULIN REACTOR	011	1
WELL CHILD CARE	818	4
		-----
	Total:	133

RUN TIME (H.M.S): 0.0.3  
End of report. HIT RETURN:

---

---

## LOC APC Visit Counts by Location of Service

This option generates a list of the number of visits by location for a specified date range. The visits included are those that meet the definition of an APC visit.

---

```

*****
*   SAN XAVIER HEALTH CENTER                                FEB 7,1995  Page 1 *
*
*           NUMBER OF APC VISITS BY LOCATION OF SERVICE    *
*           LOCATION OF VISITS:  ALL                        *
*           REPORT DATE:  DEC 31, 1994 TO DEC 31, 1994    *
*****

```

LOCATION OF SERVICE	LOCATION CODE	# VISITS
ALBUQUERQ HO	202101	3
SAN XAVIER HEALTH CENTER	000111	56
SELLS HOSPITAL/CLINIC	000101	7
SELLS UNDES	000199	2
		-----
	Total:	68

---



**AVCS Average Number of Visits by Day/Clinic ALL Service**

This report generates the average daily outpatient visit counts by Clinic for each day of the week. You will specify the date range for calculating the average daily patient visits.

**Note:** This report is similar to the Average Number of Visits by Day of Week and Clinic (AVCL), but ALL Service Categories and Clinics are included in the visit count.

```

*****
*
*   SELLS HOSPITAL/CLINIC                      APR 09, 1996   Page 1 *
*
*
*
*           AVERAGE DAILY OUTPATIENT VISITS BY CLINIC
*
*
*           SERVICE CATEGORIES:  ALL
*           LOCATION OF VISITS:  ALL
*
*           REPORT DATE:  Mar 01, 1995  TO  Mar 31, 1995
*
*****
    
```

CLINIC	MONDAY	TUESDAY	WEDNESD	THURSDA	FRIDAY	SATURDA	SUNDAY
ALCOHOLISM PROGRAM	2	1	1	0	0	0	0
CHRONIC DISEASE	4	6	3	0	1	0	0
DENTAL	6	1	1	2	3	0	0
DIABETIC	4	3	6	1	0	0	0
EMERGENCY MEDICINE	1	0	1	2	0	5	4
GENERAL	4	1	3	2	5	1	0
HOME CARE	2	2	1	2	0	0	0
MEDICAL SOCIAL SERVI	0	3	1	1	0	0	0
MENTAL HEALTH	2	1	2	5	1	0	0
PHYSICAL THERAPY	2	3	5	4	1	0	0

RUN TIME (H.M.S): 0.0.2  
 End of report. HIT RETURN:

**AVD Average Number of APC Visits per Day**

This report displays the average daily outpatient visits for a specified date range. You may choose visits for one clinic, selected clinics, or all clinics. The visits included are those that meet the definition of an APC visit.

```

*****
*   SAN XAVIER HEALTH CENTER                               FEB 7,1995  Page 1 *
*
*               AVERAGE DAILY OUTPATIENT (APC) VISITS      *
*               LOCATION OF VISITS:  ALL                    *
*               REPORT DATE:  DEC 28, 1994 TO DEC 31, 1994  *
*****

```

DAY OF WEEK	AVERAGE # OF VISITS
MONDAY	3
TUESDAY	56
WEDNESDAY	7
THURSDAY	2
	-----
Total:	68

---

## CYV Calendar Year First and Revisit Summary

This report tabulates visit counts for the facility and clinic for a specified date range. Visit counts are summarized for Indian/Alaska Native and All Other Beneficiaries. You may choose visit counts for all clinics or for the specific clinics that you specify.

Subtotals for each of the following classifications are provided:

- New patient's first visit
- Established patient's first visit
- Total first visits
- All additional visits

**Note:** When generating an inclusive calendar year report, the beginning date must be the first day of the selected calendar year.

---

MONTHLY PROGRESS - VISIT SUMMARY REPORT  
 INDIAN/ALASKA NATIVE VISITS  
 Apr 09, 1996

FACILITY: SELLS HOSPITAL/CLINIC Page 1  
 DATE RANGE: JAN 01, 1995 TO DEC 30, 1995  
 LOCATION: All Locations  
 CLINIC: All Clinics

---

Report Dates: JAN 01, 1995 to DEC 30, 1995	Indian	All Other
<hr/>		
Date Range Visit Summary		
1. New Patient's First Visit	1	0
2. Established Patient's First Visit	46	3
3. Total First Visits (1-2)	47	3
4. Additional Visits (2nd,3rd,etc.)	79	16
5. SUB-TOTAL	126	19
GRAND TOTAL-ALL VISITS:	145	

---

---

## DXC APC Visit Counts by APC Major Diagnosis Category

This report generates a count of visits by Primary Diagnosis (APC Category) for a specified date range. The visits included are those that meet the definition of an APC visit.

---

```

*****
* SAN XAVIER HEALTH CENTER                                FEB 7,1995  Page 1  *
*
*              NUMBER OF APC VISITS BY PRIMARY DX (APC CATEGORY)  *
*              LOCATION OF VISITS:  SAN XAVIER HEALTH CENTER      *
*              REPORT DATE:  SEP 01, 1994 TO  SEP 01, 1994      *
*****
  
```

APC DX CATEGORY NARRATIVE	# VISITS
ACCID. POISONINGS AND VIO	5
DIS. OF CIRCULATORY SYSTE	47
DIS. OF FEMALE GENITALIA	1
DIS. OF NERVOUS SYSTEM	1
DIS. OF RESPIRATORY SYSTE	8
DIS. OF URINARY TRACT	3
ENDOCR., NUTR., & METAB.	18
INFECTIVE & PARASITIC DIS	1
MENTAL DISORDERS	4
NEOPLASMS	1
SUPPLEMENTAL	13
SYMPTOMS & ILL DEFINED CO	2
	-----
Total:	104

---

## NOEX List APC-1A Visits Not Exported

This report will process the same way as the 1A report; however, instead of producing a list of the visits exported to the Albuquerque Data Center, it lists all visits that did NOT export. In other words, the NOEX report includes only those visits that are not in the 1A report. Your facility should run this report on a quarterly basis to verify which visits are not exporting properly to the Data Center. **Note:** If your site is new to PCC and the APC export process, this report should be run after every export until all problems with exporting data have been resolved.

The PCC data entry staff should review this report. All visits that have not exported should be reviewed, corrected, and reflagged for export, as appropriate.

```

-----
AREA:  00      TUCSON                      PCC-APC REPORT 1A      Page 1
S.U.:  01      SELLS                      FISCAL YEAR 1994
FAC.:  000101  SELLS HOSPITAL/CLINIC        AUG 02, 1994
                                           VISITS NOT EXPORTED
-----

```

```

Total Number of APC visits counted:  20878
Total Number of those APC Visits NOT Exported:  23

```

Of the total number of visits counted in the 1A, but NOT exported to the data center, 909 were not exported because they were posted or modified after the last PCC export tape was generated.

The remaining 22 visits are listed below.

```

-----
HRN  VISIT DATE/TIME      LOCATION  TYPE SC CLIN  REASON
-----
89999 NOV 24,1993@12:15  4587      I  A  01  Inactive ICD code used
79999 NOV 27,1993@14:30  4587      I  A  01  Inactive ICD code used
69999 DEC 4,1993@14:45   4587      I  A  01  No Community of Residence
59999 DEC 16,1993@14:05 4587      I  A  01  No Community of Residence
49999 DEC 18,1993@15:30 4587      I  A  01  No Community of Residence
29999 DEC 22,1993@10:00 4587      I  A  01  No Community of Residence
99999 DEC 30,1993@14:20 4587      I  A  01  No Community of Residence
08888 JAN 5,1994@08:10   4587      I  A  24  No Community of Residence
18888 JAN 13,1994@14:00 4587      I  A  01  No Community of Residence
28888 JAN 13,1994@12:00 4587      I  A  01  No Community of Residence
38888 MAR 11,1994@12:45 4587      I  A  01  No Community of Residence
48888 MAR 19,1994@12:40 4587      I  A  01  ??????
58888 APR 6,1994@14:45   4587      I  A  50  ??????
68888 APR 6,1994@13:30 4587      I  A  01  No Community of Residence
78888 APR 13,1994@09:00 4587      I  A  24  ??????
88888 APR 20,1994@09:30 4587      I  A  24  No Community of Residence
98888 APR 15,1994@12:00 4587      I  A  43  ??????
07777 APR 23,1994@12:30 4587      I  A  01  No Community of Residence
27777 APR 28,1994@09:10 4587      I  A  17  No Community of Residence
27777 APR 29,1994@12:05 4587      I  A  01  No Community of Residence
27777 JUN 8,1994@09:30   4587      I  A  24  No Community of Residence

```

```

RUN TIME (H.M.S): 0.31.34
End of report. HIT RETURN

```



## PCCV Ambulatory Visit Counts

This set of reports will count all PCC Ambulatory Visits in a given time frame. These reports display a count of PCC Ambulatory Visits sorted by the attribute you select. You will be prompted to enter the visit date range to be used in calculating the number of visits and to indicate for which location the report should print.

The following PCC Visit Count reports are available from the PCCV menu:

```
*****
**      PCC Management Reports      **
**      PCC Ambulatory Visit Counts  **
*****
Version 3.0

SELLS HOSPITAL/CLINIC

DATE  Visit Counts by Date of Visit
CLIN  Visit Counts by Clinic Type
DISC  Visit Counts by Provider Discipline
PROV  Visit Counts by Provider
DX     Visit Counts by Diagnosis (ICD)
LOC   Visit Counts by Location of Service
SC    Visit Counts by Service Category
AA    PCC Visits (By Provider Disc) PCC Report AA
ALL   ALL Visits by Provider or Provider Discipline
APPT  Tally of Walk-in/Appointment Clinic Visits
DAR   PCC Data Analysis Report
PPD   Primary Provider Visits - Daily/Annual Report
PPM   Primary Provider Visits - Monthly Report
WAIT  Wait Times by Clinic and Provider
```

In order for a visit to be included in the PCC Ambulatory Visits reports, it must meet the following criteria:

1. A Visit Type of:
  - IHS
  - 638 Program
  - Tribal
  - Other

2. A Service Category of:

- Ambulatory
- Observation
- Day Surgery
- Not Found
- Nursing Home
- Telecommunications

EXCLUDES: Chart Review, Hospitalization, In-Hospital, and Event.

3. Include a VALID primary provider.

4. Have a Purpose of Visit.

---

## DATE    Visit Counts by Date of Visit

This report counts visits by Date of Visit for the date range you specify. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

---

APR 09, 1996    Page 1

NUMBER OF AMBULATORY VISITS BY DATE OF VISIT  
 LOCATION OF VISITS:    ALL  
 VISIT DATES:    MAR 01, 1995    TO    MAR 31, 1995

LOCATION OF VISIT	DATE OF VISIT	DAY OF WEEK	# VISITS
-----			
SELLS HOSPITAL/CLINIC			
	MAR 01, 1995	WEDNESDAY	1
	MAR 06, 1995	MONDAY	1
	MAR 13, 1995	MONDAY	3
	MAR 15, 1995	WEDNESDAY	4
	MAR 20, 1995	MONDAY	1
	MAR 25, 1995	SATURDAY	1
	MAR 28, 1995	TUESDAY	1
			-----
		Total:	12

RUN TIME (H.M.S): 0.0.0  
 End of report.    HIT RETURN:

---

---

## CLIN Visit Counts by Clinic Type

This report counts visits by Clinic Type for the date range you specify. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

---

FEB 8, 1995 Page 1

NUMBER OF AMBULATORY VISITS BY CLINIC TYPE  
 LOCATION OF VISITS: SAN XAVIER HEALTH CENTER  
 VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT		
TYPE OF CLINIC	CLINIC CODE	# VISITS
-----		
SAN XAVIER HEALTH CENTER		
DIABETIC	06	12
EMERGENCY MEDICINE	30	6
GENERAL	01	20
NO CLINIC ENTERED	99999	8
PODIATRY	65	8
WELL CHILD	24	2
		-----
	Subtotal:	56

---

## DISC Visit Counts by Provider Discipline

This report counts visits by Provider Discipline for the date range you specify. You may choose counts for primary providers only or for all providers. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

FEB 8,1995 Page 1

NUMBER OF AMBULATORY VISITS BY ALL PROVIDER DISCIPLINES

LOCATION OF VISITS: SAN XAVIER HEALTH CENTER

VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT	DISCIPLINE CODE	# VISITS
PROVIDER DISCIPLINE	DISCIPLINE CODE	# VISITS
-----		
SAN XAVIER HEALTH CENTER		
CHN/AIDES	13	5
DENTIST	52	7
INTERNAL MEDICINE	71	1
LICENSED PRACTICAL NURSE	05	12
NURSE ASSISTANT	22	7
NURSE MIDWIFE	17	1
NURSE PRACTITIONER	21	4
NUTRITIONIST	07	2
OPHTHALMOLOGIST	79	1
OPTOMETRIST	08	1
PHARMACIST	09	13
PHARMACY PRACTITIONER	30	2
PHYSICIAN	00	37
PHYSICIAN ASSISTANT	11	3
REGISTERED NURSE	01	12
		-----
	Subtotal:	108
		-----
	Total:	108

## PROV Visit Counts by Provider

This report counts visits by Provider of Service for the date range you specify. You may choose counts for primary providers only or for all providers. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

FEB 8,1995 Page 1

NUMBER OF AMBULATORY VISITS BY ALL PROVIDERS OF SERVICE  
 LOCATION OF VISITS: SAN XAVIER HEALTH CENTER  
 VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT PROVIDER OF SERVICE	DISCIPLINE OF PROV	# VISITS
-----		
SAN XAVIER HEALTH CENTER		
BLACK, HAROLD C	DENTIST	2
BODE, AMY	PHYSICIAN	1
COMMUNITY HEALTH NURSE, IH	CHN/AIDES	3
DENTAL COSTEP	DENTIST	1
DENTIST, IHS	DENTIST	4
DODGE, FRANK	PHARMACIST	4
ENOS, SUSIE	REGISTERED NURSE	1
FOLSON, MALINDA	LICENSED PRACTICAL N	3
GONZALES, EVELYN	NURSE PRACTITIONER	4
INTERNIST, IHS	INTERNAL MEDICINE	1
JONES, DELPHINE	NURSE ASSISTANT	1
JOSE, MARY	LICENSED PRACTICAL N	6
LICENSED PRACTICAL NURSE,	LICENSED PRACTICAL N	1
LIVINGSTON, ROBERT	PHYSICIAN	3
LOGAN, DAVID	PHYSICIAN	1
LOPEZ, FRANCES	REGISTERED NURSE	2
MARFIN, TONY	PHYSICIAN	2
MARTIN, GRETCHEN	REGISTERED NURSE	4
MCDONALD, FRED	PHYSICIAN	1
MCGHEE, ROGER	PHARMACIST	3
	Subtotal:	----- 48
	Total:	----- 48

## DX Visit Counts by Primary Diagnosis (ICD)

This report counts visits by Primary Diagnosis (ICD Code) for the date range you specify. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

FEB 8, 1995 Page 1

NUMBER OF AMBULATORY VISITS BY PRIMARY DX (ICD CODE)

LOCATION OF VISITS: SAN XAVIER HEALTH CENTER

VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT ICD DX NARRATIVE	ICD DX CODE	# VISITS
-----		
SAN XAVIER HEALTH CENTER		
ABN GLUCOSE-ANTEPARTUM	648.83	1
ACUTE BRONCHIOLITIS	466.1	1
ACUTE NASOPHARYNGITIS	460.	1
ACUTE URI NOS	465.9	5
ANEMIA-ANTEPARTUM	648.23	1
ANXIETY STATE NOS	300.00	1
ATTEN-SURG DRESSNG/SUTUR	V58.3	1
BURN NOS	949.0	1
CHRONIC SINUSITIS NOS	473.9	2
CONGESTIVE HEART FAILURE	428.0	1
DENTAL DISORDER NOS	525.9	1
DENTAL EXAMINATION	V72.2	4
DIAB OPHTHAL MANIF ADULT/	250.50	1
DIABETES UNCOMPL ADULT/NI	250.00	9
EDEMA OF PENIS	607.83	1
FX ANKLE NOS-CLOSED	824.8	1
GINGIV/PERIODONT DIS NOS	523.9	1
HYPERMETROPIA	367.0	1
HYPOVOLEMIA	276.5	1
IMPETIGO	684.	1
		-----
	Subtotal:	36
		-----
	Total	36

## LOC Visit Counts by Location of Service

This report counts visits by Location of Service for the date range you specify.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

---

FEB 8,1995 Page 1

NUMBER OF AMBULATORY VISITS BY LOCATION OF SERVICE  
 LOCATION OF VISITS: ALL  
 VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT	LOCATION CODE	# VISITS
LOCATION OF SERVICE		
<hr style="border-top: 1px dashed black;"/>		
ALBUQUERQ HO	202101	3
SELLS HOSPITAL/CLINIC	000101	14
SAN XAVIER HEALTH CENTER	000111	57
HOME	000189	1
SELLS UNDES	000199	2
VAYA CHIN HEALTH STATION	000132	1
	Total:	----- 78

---

---

## SC Visit Counts by Service Category

This report counts visits by Service Category for the date range you specify. The report provides subtotals by Location of Encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

---

FEB 8, 1995 Page 1

NUMBER OF AMBULATORY VISITS BY SERVICE CATEGORY OF VISIT  
 LOCATION OF VISITS: SAN XAVIER HEALTH CENTER  
 VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

LOCATION OF VISIT	SERVICE CATEGORY	CODE	# VISITS
<hr style="border-top: 1px dashed black;"/>			
SAN XAVIER HEALTH CENTER			
	AMBULATORY	A	56
	NOT FOUND	N	1
	DAY SURGERY	S	2
	TELECOMMUNICATIONS	T	6
		Subtotal:	----- 65
		Total:	----- 65

---

## **AA PCC Visits (by Provider Discipline) PCC Report AA**

This report prints year-to-date PCC visit counts for the facility and fiscal year that you select. Subtotals by month are for date of service. This report is similar to the AA report produced at the Albuquerque Data Center; however, it contains all PCC visits, not just those defined as APC visits.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a Primary Provider or Purpose of Visit

**Note:** This report must be printed on 132-column paper or a printer set up for condensed print.

A sample report is shown on the following page.

AREA: 00 TUCSON PCC-OUTPATIENT PATIENT CARE REPORT APR 19, 1996 Page 1  
 S.U.: 01 SELLS FISCAL YEAR 1995  
 FAC.: 000101 SELLS HOSPITAL/CLINIC

ALL PCC OUTPATIENT (NON-HOSPITAL) VISITS TO SERVICE LOCATION BY PRIMARY PROVIDER AND MONTH OF SERVICE

PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT
PHYSICIAN*	18	6.7	0	5	1	2	0	1	0	2	1	1	2	3
MEDICAL SOCIAL WORKE	43	16.1	6	1	0	0	0	0	0	0	0	5	17	14
MENTAL HEALTH	134	50.2	2	17	11	11	16	8	9	5	3	20	11	21
PHARMACY PRACTICIONE	1	.4	0	0	0	0	0	0	0	0	0	0	0	1
DENTIST	3	1.1	0	0	0	0	1	1	0	0	0	0	0	1
COMMUNITY HEALTH REP	16	6.0	0	0	0	0	12	0	0	0	4	0	0	0
INTERNAL MEDICINE*	47	17.6	1	1	5	9	2	4	5	9	3	2	2	4
FAMILY PRACTICE*	2	.7	0	0	1	0	0	0	0	0	0	1	0	0
PSYCHIATRIST*	1	.4	0	1	0	0	0	0	0	0	0	0	0	0
T O T A L	267	100.0	9	25	18	22	33	14	14	16	11	29	32	44
*TOTAL PRIMARY PVDR	68	25.5	1	7	7	11	2	5	5	11	4	4	4	7

RUN TIME (H.M.S): 0.0.2  
 End of report. HIT RETURN:

---

## ALL All Visits by Provider or Provider Discipline

This report counts all visits by Provider, Location of Service, and Service Category. All visits are in the report regardless of Type, Service Category, or Clinic. The visit must have a valid Provider and Purpose of Visit to be included. You may select one or all providers, one or all provider disciplines, all providers within one discipline, one or all locations, and whether the provider is a primary provider.

---

AUG 02, 1994 Page 1

NUMBER OF CONTACTS BY PROVIDER, LOCATION AND SERVICE CATEGORY  
 LOCATION OF VISITS: ALL  
 PROVIDER DISCIPLINE: ALL  
 PRIMARY PROVIDER ONLY  
 VISIT DATES: JAN 01, 1994 TO JAN 15, 1994

LOCATION OF VISIT SERVICE CATEGORY	# PROVIDER CONTACTS
-----	
Provider Discipline: PHYSICIAN	
SELLS HOSPITAL/CLINIC	
AMBULATORY	36
SAN XAVIER HEALTH CENTER	
AMBULATORY	106
CHART REVIEW	4
TELECOMMUNICATIONS	4
AMBULANCE,000177	
AMBULATORY	4
CHS PHYSICIAN OFFICE,000188	
AMBULATORY	7
IN HOSPITAL	6
VETERANS ADMIN HOSPITAL	
AMBULATORY	4
HOSPITALIZATION	1
SAINT MARY'S HOSPITAL	
AMBULATORY	5

(Sub totals and Totals will be displayed)

---

## APPT Tally of Walk-in/Appointment Clinic Visits

This report counts visits by Clinic in the date range you select. You may select visit counts for one or all locations and one or all clinics. The report counts each clinic visit by appointment, walk-in, or unspecified.

AUG 02, 1994 Page 1

TALLY OF CLINIC VISITS: WALK-IN, APPOINTMENT, UNSPECIFIED

LOCATION OF VISITS: ALL

CLINIC: ALL

VISIT DATES: JAN 01, 1994 TO JAN 31, 1994

LOCATION OF VISIT		CLINIC	TOTAL	APPOINTMENTS		WALK-INS		UNSPECIFIED	
CLINIC	CODE	#	VISITS	#	%	#	%	#	%
SELLS OTHER									
MENTAL HEALTH	14	5		0	0.0	0	0.0	5	100.0
	Sub total:	5		0	0.0	0	0.0	5	100.0
SELLS HOSPITAL/CLINIC									
CHRONIC DISEASE	50	17		0	0.0	0	0.0	17	100.0
DENTAL	56	186		0	0.0	0	0.0	186	100.0
DIABETIC	06	55		0	0.0	0	0.0	55	100.0
DIETARY	67	18		0	0.0	0	0.0	18	100.0
EMERGENCY MEDICINE	30	228		0	0.0	0	0.0	228	100.0
GENERAL	01	551		0	0.0	0	0.0	551	100.0
GROUP SERVICES	09	9		0	0.0	0	0.0	9	100.0
GYNECOLOGY	10	15		0	0.0	0	0.0	15	100.0
MENTAL HEALTH	14	3		0	0.0	0	0.0	3	100.0
OBSTETRICS	16	49		0	0.0	0	0.0	49	100.0
OPHTHALMOLOGY	17	27		0	0.0	0	0.0	27	100.0
OPTOMETRY	18	31		0	0.0	0	0.0	31	100.0
OTHER	25	10		0	0.0	0	0.0	10	100.0
PHARMACY	39	203		0	0.0	0	0.0	203	100.0
PHYSICAL THERAPY	34	86		0	0.0	0	0.0	86	100.0
PODIATRY	65	29		0	0.0	0	0.0	29	100.0
RADIOLOGY	63	2		0	0.0	0	0.0	2	100.0
SURGICAL	23	13		0	0.0	0	0.0	13	100.0
WELL CHILD	24	10		0	0.0	0	0.0	10	100.0
WOMEN'S HEALTH SCREE	70	1		0	0.0	0	0.0	1	100.0
	Sub total:	1543		0	0.0	0	0.0	1543	100.0
Total		1548		0	0.0	0	0.0	1548	100.0

## DAR PCC Data Analysis Report

This report counts all visits processed in the PCC and categorizes them by Type, Service Category, and Complete/Incomplete. It also indicates which visits would be excluded from the APC System.

SELLS HOSPITAL/CLINIC

Apr 09, 1996 Page 1

### PCC DATA ANALYSIS REPORT

\*\*\*\*\*

FACILITY: SELLS HOSPITAL/CLINIC - 000101  
 VISIT DATE RANGE: Jan 01, 1995 - Dec 30, 1995

Total Visits Processed in PCC: 140

as of the Date the report was run:

	# complete -----	# incomplete -----
TYPE:		
IHS	100	36
OTHER	3	1
SERVICE CATEGORY:		
AMBULATORY	97	34
CHART REVIEW	1	
EVENT (HISTORICAL)		1
HOSPITALIZATION	2	2
IN HOSPITAL	3	

APC Acceptable Visits based on Headquarters Definition: 93

Exclusions from APC System:

Dental Clinic w/o Medication	4
Other Excluded Clinic Type	0
Incomplete A, O, R or S	15
Non APC Service Category	9
Non APC Visit Type	0
Mult Visits same patient, same day, same clinic	19

Of the acceptable APC visits, 0 were posted or modified after the last export and would not be reflected in reports from the data center.

Of the acceptable APC visits, 27 were not exported due to an error. These can be reviewed using other PCC reports.

RUN TIME (H.M.S): 0.0.9  
 End of report. HIT RETURN:

## PPD Primary Provider Visits - Daily/Annual Report

This report counts visits by Primary Providers for a given day or year. You may specify the locations or clinics to include in the report up to a total of 6 for an 80-column report or 12 for a 132-column report. All clinics are counted in the report, including Telephone Calls, Dental, and Chart Reviews if a clinic is not specified. However, only visits with a Primary Provider Discipline in one of the following codes are tabulated:

00 - Physician	44 - Physician (Tribal)
11 - Physician Assistant	70-90 - Physician Specialists
16 - Pediatric Nurse Practitioner	18 - Contract Physician
17 - Nurse Midwife	25 - Contract Podiatrist
21 - Nurse Practitioner	41 - Contract OB/Gyn
33 - Podiatrist	

The following sample report was run for an entire facility and six specific clinics for January 15, 1995.

---



---

PROVIDER	GENERAL	DIABETIC	INTERNAL	OBSTETRI	SURGICAL	EMERGENC
SELLS HOSPITAL/CLINIC <span style="float: right;">Page 1</span> PRIMARY CARE PROVIDER VISITS - YEARLY REPORT VISIT DATES: JAN 15, 1995 TO JAN 15, 1995 LOCATION OF VISITS: ALL						
CURTIS, CLAYTON	10	2	0	0	0	3
SHORR, GREG	2	2	0	0	0	0
BUTCHER, LORI AN	18	0	0	0	0	0
RUN TIME (H.M.S): 0.0.0 End of report. HIT RETURN:						

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## PPM Primary Care Provider Visits – Monthly Report

Similar to the previous report, the PPM report counts the number of visits by primary care providers for a given month. All clinic codes are in the report including Telephone Calls, Dental, and Chart Review. Only visits with a Primary Provider Discipline (identified on the previous page) are counted.

The following sample report was run for the month of January for six selected clinics.

---



---

DATE	GENERAL	DIABETIC	INTERNAL	OBSTETRI	EMERGENC	DENTAL
SELLS HOSPITAL/CLINIC <span style="float: right;">Page 1</span>						
PRIMARY CARE PROVIDER VISITS - PRIMARY PROVIDER ONLY						
VISITS DATES: JAN 01, 1996 TO JAN 31, 1996						
LOCATION OF VISITS: ALL						
-----						
01/08/96	1	4	11	9	3	5
01/10/96	6	6	9	7	1	6
01/11/96	4	7	6	5	2	3
01/18/96	2	5	7	5	0	5
01/24/96	8	5	6	3	2	5
01/30/96	1	5	8	2	1	7
-----						
RUN TIME (H.M.S): 0.0.0						
End of report. HIT RETURN:						

---



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## WAIT Wait Times by Clinic and Provider

The WAIT report displays minimum, maximum, and mean waiting times by provider and clinic. In order for data to print in this report, your site must be entering the actual time that the primary provider saw the patient.

You will enter a beginning visit date and ending visit date for the time reporting. Then you have the option of printing waiting times for all clinics or only specific clinics that you enter.

The sample report below includes wait times for the Internal Medicine clinic between October 1 and October 31, 1996.

```

*****
*   SELLS HOSPITAL/CLINIC                               NOV 25, 1996 Page 1 *
*
*           WAITING TIMES BY CLINIC AND PROVIDER        *
*   LOCATION OF VISITS:  SELLS HOSPITAL/CLINIC        *
*   REPORT DATE:  OCT 01, 1996 TO OCT 31, 1996        *
*****

```

CLINIC	TOTAL VISITS	# VSTS USED	AVG WAIT	MIN WAIT	MAX WAIT	# EARLY	# LATE
INTERNAL MEDICINE	120	100	10	0	33	38	62
BEGAY, TED	25	20	18	5	37	0	20
MARTINEZ, LUPE	40	40	5	0	12	18	22
SMITHEREEN, TOM	30	25	12	2	23	6	19
QUARTZ, FLYNN	25	15	8	0	18	6	9

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## BILL Billing Reports

The following reports are available from the Billing Reports menu:

*****	
**	PCC Management Reports **
**	Billing Reports **
*****	
Version 3.0	
SELLS HOSPITAL/CLINIC	
MCA	Listing of Active Medicare Part A Enrollees
MCB	Listing of Active Medicare Part B Enrollees
MCD	Listing of Active Medicaid Enrollees
PI	Listing of Active Private Insurance Enrollees
CO	Listing of Commissioned Officers and Dependents
VIS	Listing of Potentially Billable Visits by Date
COV	Visits by Commissioned Officers and Dependents

---

**MCA Listing of Active Medicare Part A Enrollees**

This option prints a list of patients currently enrolled in Medicare Part A who are registered at the facility you select. You will enter an "as of" date for identifying those patients who are actively enrolled from the date you have specified. The report sorts alphabetically by Patient Name.

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SAN XAVIER HEALTH CENTER Page 1  
REGISTERED PATIENTS - ACTIVE MEDICARE PART A ENROLLEES  
Actively enrolled as of FEB 7,1995

(TYPE)	NAME COVERAGE	CHART # ELIG BEG DATE	MEDICARE # ELIG END DATE	DATE OF BIRTH
(REG)	BROWN, SUSAN	6182	56932812361	FEB 01, 1938
(MCR)	WASHINGTON, HENRY A	SEP 1979		
	A	DEC 31, 1988		
(REG)	GREEN, DARLENE	6708	1234344441	JAN 01, 1989
(MCR)	WASHINGTON, HENRY A	DEC 31, 1988		
(REG)	MARTIN, BILL	14697	57416683018	JUN 01, 1975
(MCR)	A	JUL 1975		

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**MCB Listing of Active Medicare Part B Enrollees**

This option prints a list of patients currently enrolled in Medicare Part B who are registered at the facility you select. You will enter an "as of" date for identifying those patients who are actively enrolled from the date that you have specified. The report sorts alphabetically by Patient Name.

---

SAN XAVIER HEALTH CENTER  
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES  
Actively enrolled as of FEB 7,1995

Page 1

(TYPE)	NAME COVERAGE	CHART # ELIG BEG DATE	MEDICARE # ELIG END DATE	DATE OF BIRTH
(REG) (MCR)	BLACK, LISA B	9422 JUL 1966	526928682144	SEP 01, 1964
(REG) (MCR)	BROWN, SUSAN WASHINGTON, HENRY B	6182 SEP 1979	56932812361	FEB 01, 1938
(REG) (MCR)	GREEN, DARLENE WASHINGTON, HENRY B	6708 DEC 13, 1989	1234344441	JAN 01, 1989

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**MCD Listing of Active Medicaid Enrollees**

This option prints a list of patients currently enrolled in Medicaid who are registered at the facility you select. You will enter an "as of" date for determining those patients who are actively enrolled from the date that you have specified. The report sorts alphabetically by Patient Name.

---

SAN XAVIER HEALTH CENTER  
REGISTERED PATIENTS - ACTIVE MEDICAID ENROLLEES  
Actively enrolled as of FEB 7,1995

Page 3

PATIENT NAME	CHART #	DATE OF BIRTH
(REG) BROWN,SAM (MCD)	20829	MAY 01, 1977
MEDICAID #: 517944044 NAME/INSURED:		STATE: MONTANA SEX OF INSURED:
(REG) BROWN,SUSAN (MCD)	6182	FEB 01, 1938
MEDICAID #: 5276196964 NAME/INSURED: ELIG BEG DATE: JAN 1983	COVERAGE: 11	STATE: ARIZONA SEX OF INSURED: ELIG END DATE:
(REG) GREEN,DARLENE (MCD) SAME	6708	JAN 01, 1989
MEDICAID #: 8888888888 NAME/INSURED: GREEN,DARLENE ELIG BEG DATE: JAN 31, 1990	COVERAGE:	STATE: MINNESOTA SEX OF INSURED: F ELIG END DATE: FEB 14, 1990

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**PI Listing of Active Private Insurance Enrollees**

This option prints a list of patients currently enrolled in private insurance who are registered at the facility you select. You will enter an "as of" date for identifying those patients who are actively enrolled from the date that you specify. The report sorts alphabetically by Patient Name.

---

SAN XAVIER HEALTH CENTER  
REGISTERED PATIENTS - ACTIVE PRIVATE INSURANCE ENROLLEES  
Actively enrolled as of FEB 7,1995

Page 1

PATIENT NAME	CHART #	DATE OF BIRTH
GREEN, ANNE INSURER: AETNA POLICY #: 123456 INSURED: ENOS, D ELIG BEG DATE: JAN 27, 1988	16132	MAY 01, 1935 COVERAGE TYPE: REL: SELF ELIG END DATE:
GREEN, DARLENE INSURER: BLUE CROSS/BLUE SHIELD POLICY #: 123434444 INSURED: WASHINGTON, HENRY ELIG BEG DATE: JAN 01, 1989	6708	JAN 01, 1989 COVERAGE TYPE: REL: SELF ELIG END DATE:

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TOTAL NUMBER OF ACTIVE PRIVATE INSURANCE ENROLLEES: 2

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## CO Listing of Commissioned Officers and Dependents

This report lists commissioned officers and their dependents as of the current date.

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page 1

SAN XAVIER HEALTH CENTER  
 COMM. OFFICERS & DEPENDENTS  
 UCI: DEV  
 ("\*" = INACTIVE)  
 as of FEB 7,1995@18:54:08

Name	IHS #	SSN	CLASS.
BENSON, ELIZABETH CAROL	22407	558578561	C. O.
BLACK, BILL	10050	520369922	C. O.
BROWN, BILL	13622	402522794	C. O.
BROWN, SAM	11994	504441570	C. O.
DICKEY, ELIZABETH	20974	387444460	C. O.
GOETTERT, JUDY	20923	562908860	C. O.
GOLDBECK, ANDREW PAUL	21037	143466019	C. O.
HALL, JULIE PATRICIA	20780	391525918	C. O.
HEROLD, DOUGLAS PAUL	21632	479723617	C. O.

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## VIS Listing of Potentially Billable Visits by Date

This option prints a list of potentially billable visits for all patients registered at the facility you select. This report displays visits for the period in which the patient had third-party coverage. Only visits at the location where a patient is registered will display. Note that specific diagnostic categories which may not be covered by the patient's insurance are not considered in the report.

You may select to display visits from the following types of third-party coverage:

1. Commissioned Officers/Dependents
2. Medicare Part A
3. Medicare Part B
4. Medicaid
5. Private Insurance
6. Non-Indians
7. All Above Coverages

The following sample report shows billable visits from September 1, 1988 to February 7, 1990 for patients enrolled in Medicare Part B.

HRCN	Patient Name	Date of Birth	SSN
SAN XAVIER HEALTH CENTER			
POTENTIALLY BILLABLE VISITS FOR Medicare Part B			
Visit Dates: SEP 1,1988 and FEB 7,1990			
14697	MARTIN,BILL	JUN 01, 1975	527739228
	Medicare Name:		DOB: JUN 01, 1975
	Coverage: B	Beg. Date: JUL 1975	End. Date:
	Medicare #: 527739228B		
	Visit Date	Category	PRV ICD DX ICD NARRATIVE
	JAN 01, 1990	AMBULATORY	00 465.9 ACUTE URI NOS
4500	MARTIN,LISA	AUG 01, 1935	111991111
	Medicare Name:		DOB: AUG 01, 1935
	Coverage: B	Beg. Date: MAR 21, 1987	End. Date:
	Medicare #: 111991111B		
	Visit Date	Category	PRV ICD DX ICD NARRATIVE
	OCT 21, 1988	AMBULATORY	00 250.00 DIABETES UNCOMPL ADU
			250.91 DIAB W COMPL NOS JUV
	MAR 28, 1989	AMBULATORY	52 V72.2 DENTAL EXAMINATION
	OCT 24, 1989	AMBULATORY	71 250.00 DIABETES UNCOMPL ADU

---

## COV Visits by Commissioned Officers and Dependents

This report displays visits for all commissioned officers and their dependents at the facility you are logged in to. You will specify a date range for the visits and select from the following types of visits:

1. Outpatient Visits Only
2. Inpatient Visits Only
3. Dental Visits Only
4. All Visits

**Note:** This report prints on 132-column paper or on a printer set up for condensed print.

---



---

\*\*\*\*\*Confidential Patient Data Covered by Privacy Act\*\*\*\*\*

SELLS HOSPITAL/CLINIC  
 COMMISSIONED OFFICERS & DEPENDENTS VISITS  
 09/01/88 TO 12/31/88  
 OUTPATIENT VISITS

Patient Name	Chart #	SSN	CO or Dep	Sponsor	SSN	Visit Date	No. Of Visits
MARTIN, LISA	97	111991111	CO			09/02/88	
						11/22/88	
						11/23/88	
						12/08/88	4
TOTAL OUTPATIENT VISITS							4

---



---

## BMI Body Mass Index Reports

This menu provides options for producing lists and summary tables to reflect the prevalence of overweight and obese patients in a Service Unit or facility for the PCC active user population. Patients aged 2-74 are included in the reports. Height and weight measurements are used to calculate Body Mass Index (BMI). BMI is then compared to age- and sex-specific standard reference values obtained from the second National Health and Nutrition Examination Survey (NHANES II). The overweight category is determined by  $\geq$  NHANES 85th percentile and the obese category is determined by  $\geq$  NHANES 95th percentile.

This information is useful to Public Health Nutritionists and Dietitians and other related health and administrative personnel for program planning, monitoring, and assessing trends in the active user population. The data does not represent the general American Indian/Alaska Native population, but is useful to partially address the need for ongoing data collection and monitoring identified in the National Health Objectives for the Year 2000.

The usefulness and accuracy of these reports are directly affected by the regularity and accuracy of height and weight measurements. To be included in these reports, patient records must:

- Have a visit recorded within the past 3 years (active users)
- Have current height and weight measurements:
  - Height and weight taken on the same day within the past year (ages 2-19)
  - Height and weight taken within the past 3 years (ages 20-74)

Excluded from these reports are patient records whose BMI falls above or below the data check limit and prenatal patients.

Each of the six BMI report options allows you to use a search template of patients for generating these reports. You may use search templates created in Q-Man or any that you have created when running other PCC management reports. The following reports are available:

```
*****
**      PCC Management Reports      **
**      Body Mass Index Reports     **
*****
                          Version 3.0

                          SELLS HOSPITAL/CLINIC

OOPT  Overweight/Obesity Prevalence Table
LPAT  Listing of Patients with Height/Weight/BMI
OVER  Listing of Overweight Patients
OBES  Listing of Obese Patients
COMB  Combined Listing of Overweight/Obese Patients
ERR   List of Patients with Potential Ht/Wt Error
REF   BMI Standard Reference Data Table
```

**Estimated Run Time:** These reports may require lengthy run times. Please contact your local Site Manager for help with determining which reports to queue.

## OOPT Overweight/Obesity Prevalence Table

This option reviews and counts patient records to indicate those who are overweight and obese. You may search all patient records or use a predefined search template. Result totals are available by Age or Sex.

---

LAB SELLS HOSPITAL/CLINIC Page 1  
OVERWEIGHT/OBESITY PREVALENCE REPORT

Report includes: FEMALES

AGE	TOTAL # PATIENT RECORDS USED	AVERAGE BMI	RANGE	OVERWEIGHT (>= NHANES 85TH%)		OBESE (>= NHANES 95TH%)	
				#	%	#	%
2-4	786	17.8	10.9- 33.2	490	63.3	282	35.9
5-14	1778	22.7	11.4- 51.7	1022	57.5	568	31.9
15-19	486	31.1	17.3- 57.9	356	73.3	248	51.0

---

## LPAT Listing of Patients with Height/Weight/BMI

This report produces a list of all patients for the Age Range and Sex you specify. You may search all patient records or use a predefined search template. The report displays Weight, Height, Age, Sex, and BMI. The data may be sorted by Patient Name, Age, or BMI. For this report, you may suppress identifying data.

---

LAB SELLS HOSPITAL/CLINIC Page 1  
OVERWEIGHT/OBESITY PREVALENCE REPORT  
PATIENT LISTING

Report includes: MALES & FEMALES / ALL AGES

PATIENT NAME	HRN #	HEIGHT	WEIGHT	DATE OF WEIGHT	AGE	SEX	BMI	>=	>=
								NHANES 85TH%	NHANES 95TH%
WATERMAN,RAE	100444	60.0	100.0	10/05/94	60	F	20.1	N	N
CARTER,MEGAN	100117	39.4	220.5	10/01/94	39	F	103.0	Y	Y
FLINTSTONE,JUDY	100041	39.0	220.5	09/24/94	45	F	105.1	Y	Y
TOTAL NUMBER OF PATIENTS: 3									

---

## OVER Listing of Overweight Patients

This report lists all patients who are considered overweight based on BMI for the Age Range and Sex you specify. The data may be sorted by Patient Name, Age, or BMI. For this report, you may suppress identifying data.

---



---

LAB	SELLS HOSPITAL/CLINIC							Page 1	
	OVERWEIGHT/OBESITY PREVALENCE REPORT								
	LIST OF OVERWEIGHT PATIENTS								
	Report includes: MALES & FEMALES / ALL AGES								
								>=	>=
				DATE OF				NHANES	NHANES
PATIENT NAME	HRN #	HEIGHT	WEIGHT	WEIGHT	AGE	SEX	BMI	85TH%	95TH%
SMITH, JOHN M	3344	68.0	284.0	08/11/94	16	M	44.	Y	Y
ANOTHER, PATIENT	5555	66.8	194.0	02/02/94	15	M	31.5	Y	Y

---



---

## OBES Listing of Obese Patients

This report lists all patients who are considered obese based on BMI for the Age Range and Sex you specify. The data may be sorted by Patient Name, Age, or BMI. For this report, you may suppress identifying data.

---



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LAB	SELLS HOSPITAL/CLINIC							Page 1	
	OVERWEIGHT/OBESITY PREVALENCE REPORT								
	LIST OF OBESE PATIENTS								
	Report includes: MALES & FEMALES / ALL AGES								
								>=	>=
				DATE OF				NHANES	NHANES
PATIENT NAME	HRN #	HEIGHT	WEIGHT	WEIGHT	AGE	SEX	BMI	85TH%	95TH%
SMITH, JOHN M	3344	68.0	284.0	08/11/94	16	M	44.	Y	Y
ANOTHER, PATIENT	5555	66.8	194.0	02/02/94	15	M	31.5	Y	Y

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---

## COMB Combined Listing of Overweight/Obese Patients

This report lists all patients who are considered overweight or obese based on BMI for the Age Range and Sex you specify. The data may be sorted by Patient Name, Age, or BMI. For this report, you may suppress identifying data.

---



---

LAB Page 1

SELLS HOSPITAL/CLINIC  
OVERWEIGHT/OBESITY PREVALENCE REPORT  
COMBINED LIST OF OVERWEIGHT/OBESE PATIENTS

Report includes: MALES & FEMALES / ALL AGES

PATIENT NAME	HRN #	HEIGHT	WEIGHT	DATE OF WEIGHT	AGE	SEX	BMI	>=	>=
								NHANES 85TH%	NHANES 95TH%
SMITH, JOHN M	3344	68.0	284.0	08/11/94	16	M	44.	Y	Y
ANDREWS, DOUGLAS	3333	70.3	181.5	11/23/94	16	M	26.6	Y	N
ANOTHER, PATIENT	5555	66.8	194.0	02/02/94	15	M	31.5	Y	Y

---



---

## ERR Listing of Patients with Potential Height/Weight Error

This report lists all patients whose Body Mass Index (BMI) falls below or exceeds the data check limits (see the BMI Standard Reference Table on the following page) for the Age Range and Sex you specify. The data may be sorted by Patient Name, Age, or BMI. For this report, you may suppress identifying data.

**Note:** These patient records should be checked for possible inaccurate height or weight entries.

---



---

LAB Page 1

SELLS HOSPITAL/CLINIC  
OVERWEIGHT/OBESITY PREVALENCE REPORT  
LIST OF PATIENTS WITH BMI OUTSIDE EDIT RANGE

Report includes: MALES & FEMALES / ALL AGES

PATIENT NAME	HRN #	HEIGHT	WEIGHT	DATE OF WEIGHT	AGE	SEX	BMI	>=	>=
								NHANES 85TH%	NHANES 95TH%
BROEN, LENORE	100182	55.0	8.8	08/25/94	57	F	2.1	N	N
CARTER, MEGAN	100117	39.4	220.5	10/01/94	39	F	103.0	Y	Y
FLINTSTONE, JUDY	100041	39.0	220.5	09/24/94	45	F	105.1	Y	Y
TOTAL NUMBER OF PATIENTS: 3									

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**REF BMI Standard Reference Data Table**

You can print the BMI Standard Reference Data Table with this menu option, as shown below.

---



---

Low-High Ages	SEX	BMI >= (overwt.)	BMI >= (obese)	BMI >	BMI <
2 - 2	MALE	17.4	18.4	36.8	7.2
	FEMALE	17.5	18.5	37.0	7.1
3 - 3	MALE	16.9	17.8	35.6	7.1
	FEMALE	16.7	17.7	35.4	6.8
4 - 4	MALE	16.8	18.1	36.2	7.0
	FEMALE	16.8	18.0	36.0	6.9
5 - 5	MALE	16.8	18.0	36.0	6.9
	FEMALE	17.2	19.6	39.2	6.8
6 - 6	MALE	17.5	21.1	42.2	7.0
	FEMALE	17.3	19.3	38.6	6.8
7 - 7	MALE	17.3	19.8	39.6	6.9
	FEMALE	17.8	19.9	39.8	6.9
8 - 8	MALE	18.7	20.8	41.6	6.9
	FEMALE	18.1	20.3	40.6	7.0
9 - 9	MALE	18.6	21.8	43.6	6.9
	FEMALE	19.6	25.2	50.4	7.1
10 - 10	MALE	20.4	24.4	48.8	7.3
	FEMALE	20.9	24.1	48.2	6.9
11 - 11	MALE	22.5	26.4	52.8	7.4
	FEMALE	21.6	26.2	52.4	7.5
12 - 12	MALE	21.6	25.0	50.0	7.5
	FEMALE	22.7	26.3	52.6	7.5
13 - 13	MALE	22.2	24.8	49.6	8.0
	FEMALE	23.2	28.5	57.0	7.6
14 - 14	MALE	23.1	25.1	50.2	8.3
	FEMALE	24.5	28.8	57.6	8.2
15 - 15	MALE	23.0	26.6	53.2	8.4
	FEMALE	22.6	26.6	53.2	8.6
16 - 16	MALE	25.4	28.0	56.0	9.1
	FEMALE	25.4	29.1	58.2	8.9

Low-High Ages	SEX	BMI >= (overwt.)	BMI >= (obese)	BMI >	BMI <
17 - 17	MALE	24.6	28.3	56.6	8.9
	FEMALE	25.1	31.3	62.6	8.7
18 - 18	MALE	26.0	29.9	59.8	9.1
	FEMALE	25.5	30.7	61.4	8.9
19 - 19	MALE	25.9	30.2	60.4	9.4
	FEMALE	25.9	29.0	58.0	9.2
20 - 74	MALE	27.8	31.1	62.2	9.7
	FEMALE	27.3	32.3	64.6	9.0



## ACT Activity Reports by Discipline Group

This set of reports provides Activity and Travel Times (in minutes) for the discipline group you select. Three discipline groups are already defined:

<u>Group</u>	<u>Discipline</u>	<u>Code</u>
PHN	CHN/Aides	13
	CHN (Contract)	32
Mental Health	Mental Health	19
	Psychiatrist	81
	Neurologist	85
	Contract Psychologist	50
	Psychologist	12
	Contract Psychiatrist	49
Social Services	Medical Social Worker	06
	Licensed Med Social Worker	62
	Contract Social Worker	63

You can define new discipline groups, as appropriate, using the CAG option. However, the only method for tracking each specific discipline is to have each provider enter an Activity Time and/or Travel Time on the PCC Encounter Form. The menu includes the following reports:

```
*****
**                PCC Management Reports                **
**      Activity Reports by Discipline Group      **
*****
                Version 3.0

                SELLS HOSPITAL/CLINIC

TSPR  Time and Patient Services by Provider
TSSU  Time and Patient Services by Service Unit
PPPR  Primary Problem by Provider
PPLO  Primary Problem by Facility
PPSU  Primary Problem by Service Unit
INPR  Number of Individuals seen by Provider
INSU  Number of Individuals seen by Service Unit
AGE   Patient Services by Age and Sex
TEN   Top Ten Primary Diagnoses
CAG   Create new Activity Discipline Group
INQA  Inquire into an Activity Group
```

**TSPR****Time and Patient Services by Provider**

This report displays the number of Patient Contacts, Total Activity Time, and Total Travel Time for each Provider by Location of Encounter within the provider discipline group you select.

You will enter a beginning and ending visit date range and the discipline group.

OCT 15,1994

Page 1

PATIENT CONTACT REPORT FOR MENTAL HEALTH STAFF  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994  
 PROVIDER: MENTAL HEALTH

LOCATION OF ENCOUNTER	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
SELLS OTHER	2	1	1	54	50
BILLINGS ADMINISTRATION	4	4	0	123	30
SELLS HOSPITAL/CLINIC	4	3	1	90	39
TOTAL:	10	8	2	267	119

\* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3  
 End of Report - Hit return

---

**TSSU Time and Patient Services by Service Unit**

This report displays Total Patient Contacts, Total Activity Time, and Total Travel Time for a selected discipline group and a specific Service Unit.

You will enter a beginning and ending visit date range and the Service Unit.

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---

OCT 15,1994

Page 1

LOCATION OF ENCOUNTER REPORT BY SERVICE UNIT FOR PHN STAFF

VISIT DATES: JAN 01, 1994 TO OCT 15, 1994

SERVICE UNIT: SELLS

LOCATION OF ENCOUNTER	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
SELLS OTHER	2	2	0	54	50
SELLS HOSPITAL/CLINIC	6	5	1	110	59
TOTAL:	8	7	1	164	119

\* -- 2 of the visits did not have an activity time recorded.

NOTE: This report counts one visit regardless of the number of PHN staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

RUN TIME (H.M.S): 0.0.3

End of Report - Hit return

---



---

---

## PPPR Primary Problem by Provider

The PPPR report totals Primary Problems for each provider in a specified discipline group. Totals for Patient Contacts, Activity Times, and Travel Times for each diagnosis are displayed.

You will enter a beginning and ending visit date range and a discipline group.

---



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OCT 15,1994

Page 1

PRIMARY PROBLEM REPORT BY PROVIDER PHN STAFF  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994  
 PROVIDER: COMMUNITY HEALTH NURSE, IHS

PRIMARY PROBLEM	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
-----					
DIABETES	2	1	1	54	50
OTHER DIS OF THE NERVOUS	4	4	0	123	30
PRENATAL, FIRST TRIMESTER	4	3	1	90	39
TOTAL:	10	8	2	267	119

\* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3  
 End of Report - Hit return

---



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## PPLO Primary Problem by Facility

This report totals Primary Problems for a specific discipline group and Location of Encounter. Totals for Activity Times, Travel Times, and Patient Contacts for each problem are displayed.

You will enter a beginning and ending visit date range and a discipline group.

---



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OCT 15,1994

Page 1

PRIMARY PROBLEM REPORT BY LOCATION OF ENCOUNTER FOR PHN STAFF

VISIT DATES: JAN 01, 1994 TO OCT 15, 1994

LOCATION OF ENCOUNTER: SELLS HOSPITAL/CLINIC

PRIMARY PROBLEM	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
DIABETES	2	1	1	54	50
OTHER DIS OF THE NERVOUS	4	4	0	123	30
PRENATAL, FIRST TRIMESTER	4	3	1	90	39
TOTAL:	10	8	2	267	119

\* -- 1 of the visits did not have an activity time recorded

NOTE: This report counts one visit regardless of the number of PHN staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

RUN TIME (H.M.S): 0.0.3

End of Report - Hit return

---



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---

## PPSU Primary Problem by Service Unit

This report displays Primary Problems for a specific Service Unit. Totals are shown for Patient Contacts, Activity Times, and Travel Times for each provider within the discipline group you select.

You will enter a beginning and ending visit date range, Service Unit, and discipline group.

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Page 1

PRIMARY PROBLEM REPORT BY SERVICE UNIT  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994  
 SERVICE UNIT: SELLS

PRIMARY PROBLEM	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
DIABETES	2	1	1	54	50
OTHER DIS OF THE NERVOUS	4	4	0	123	30
PRENATAL,FIRST TRIMESTER	4	3	1	90	39
TOTAL:	10	8	2	267	119

\* -- 1 of the visits did not have an activity time recorded

NOTE: This report counts one visit regardless of the number of PHN staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

RUN TIME (H.M.S): 0.0.3  
 End of Report - Hit return

---

---

## INPR Number of Individuals Seen by Provider

This report displays the number of individuals seen by each provider within a discipline by Location of Encounter for the discipline group you select.

You will be prompted to enter the beginning and ending visit dates and discipline group.

---



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OCT 15, 1994

Page 1

NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994 COMMUNITY HEALTH PROVIDER:  
 PROVIDER: COMMUNITY HEALTH PROVIDER, IHS

	TOTAL NUMBER OF INDIVIDUALS SEEN
SELLS OTHER	101
BILLINGS ADMINISTRATION	99
SELLS HOSPITAL/CLINIC	250
TOTAL:	450

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---

## INSU Number of Individuals Seen by Service Unit

This report displays the number of individuals seen by providers within a discipline group you select for a specified Service Unit.

You will be prompted to enter the beginning and ending visit dates and the discipline group.

---

OCT 15,1994

Page 1

NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF  
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994 COMMUNITY HEALTH NURSE:  
SERVICE UNIT: SELLS

	TOTAL NUMBER OF INDIVIDUALS SEEN
-----	
SANTA ROSA CLINIC	99
SELLS OTHER	101
SELLS HOSPITAL/CLINIC	250
TOTAL:	450

---

## AGE Patient Services by Age and Sex

The AGE report displays activity and travel times by Age and Sex for all visits in the discipline group you select. You will be prompted to enter beginning and ending visit dates and to specify the age groups.

OCT 15,1994

Page 1

TIME AND PATIENT SERVICES REPORT BY AGE AND SEX FOR PHN STAFF  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994  
 SEX: FEMALE

AGE GROUP	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
0-0 years	15	15	.	100	.
1-4 years	30	25	5	50	.
5-14 years	10	5	5	100	.
15-19 years	30	20	5	240	30
20-24 years	.	.	.	.	.
25-44 years	.	.	.	.	.
45-64 years	50	30	20	500	100
>64 years	.	.	.	.	.
TOTAL:	135	95	35	990	130

\* -- 1 of the visits did not have an activity time recorded.

OCT 15,1994

Page 2

TIME AND PATIENT SERVICES REPORT BY AGE AND SEX FOR PHN STAFF  
 VISIT DATES: JAN 01, 1994 TO OCT 15, 1994  
 SEX: MALE

AGE GROUP	TOTAL PATIENT CONTACTS	# CONTS AS PRIM. PROVIDER	# CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
0-0 years	15	15	.	100	.
1-4 years	30	25	5	50	.
5-14 years	10	5	5	100	.
15-19 years	30	20	5	240	30
20-24 years	.	.	.	.	.
25-44 years	.	.	.	.	.
45-64 years	50	30	20	500	100
>64 years	.	.	.	.	.
TOTAL:	135	95	35	990	130

\* -- 1 of the visits did not have an activity time recorded.

---

## TEN Top Ten Primary Diagnoses

This report displays the top ten primary purposes for visits by providers within the discipline group you select. The report generates for a specified Service Unit.

You will be prompted to enter the beginning and ending visit dates.

---

---

APR 10, 1996

Page 1

TOP TEN PRIMARY DX REPORT BY SERVICE UNIT PHN STAFF  
VISIT DATES: JAN 01, 1995 TO JAN 31, 1995  
SERVICE UNIT: SELLS

PRIMARY DX

TOTAL PATIENT CONTACTS

---

WELL CHILD CARE	19
DIABETES	14
HYPERTENSION	8
GENERAL/MULTIPLE	6
PRENATAL, FIRST TRIMESTER	4
OTHER SUBSTANCE ABUSE	3
TUBERCULOSIS, REACTOR/CONV	2
SCABIES	1

RUN TIME (H.M.S): 0.2.16  
End of report. HIT RETURN:

---

---

---

## CAG    Create new Activity Discipline Group

This option provides you with a means to define and create a new discipline group. Once the new group is created and providers within that discipline record their activity and travel times on the PCC Encounter Form, activity reports can be generated for the new discipline group.

---

```

Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP: NURSES
  ARE YOU ADDING 'NURSES' AS A NEW PCC MAN REPORTS ACTIVITY
GROUP (THE 4TH)? Y (YES)
NAME OF GROUP: NURSES//
Select DISCIPLINES IN GROUP: 05 LICENSED PRACTICAL NURSE
  ARE YOU ADDING 'LICENSED PRACTICAL NURSE' AS
  A NEW DISCIPLINES IN GROUP (THE 1ST FOR THIS PCC MAN REPORTS ACTIVITY
GROUP)? Y (YES)
Select DISCIPLINES IN GROUP: 01 REGISTERED NURSE
  ARE YOU ADDING 'REGISTERED NURSE' AS
  A NEW DISCIPLINES IN GROUP (THE 2ND FOR THIS PCC MAN REPORTS ACTIVITY
GROUP)? Y (YES)

```

---

## INQA    Inquire into an Activity Group

This option enables you to view an established activity group.

---

```

NAME OF GROUP: PHN                                ICD RECODE ROUTINE: APCLRCHA
  RECODE GLOBAL: AUTTCHA                          PIECE FOR DESC. IN RECODE FILE: 3
  STANDARD: YES
DISCIPLINES IN GROUP: CHN/AIDES                   DISCIPLINE CODE: 13
DISCIPLINES IN GROUP: CHN (CONTRACT)              DISCIPLINE CODE: 32

Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP:

```

---

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## CNTS Count Summary Reports

These report options provide counts of patients based upon clinical data. All of the reports available from the Count Summary menu shown below provide tallies by Diagnosis or Purpose of Visit.

```
*****
**      PCC Management Reports      **
**      Count Summary Menu          **
*****
          Version 3.0

          SELLS HOSPITAL/CLINIC

DXAG  Diagnoses by AGE report
DXFA  DX Tally by Local, Secondary, Tertiary Facility
FPRC  Frequency of Procedures Report
PAPC  Purpose of Visits grouped by APC codes
TEN   Frequency of Diagnoses Report
```

## DXAG Diagnoses by Age Report

This report lists and counts diagnoses (ICD) by Age Group. You will enter the visit date range and whether to select visits by any of the following criteria:

- Patient Age
- Facility of Encounter
- Clinic Type
- Type of Visit
- Patient Sex
- Primary Provider
- Service Category

You must also indicate whether all purposes of visits or only the primary purpose of visits are to be included in the report.

Age group categories have been predefined; however, you may modify the categories as needed.

**Note:** This report must print on 132-column paper or on a printer set up for condensed print.

SELLS HOSPITAL/CLINIC  
Diagnoses by Age Report

Visit Dates: JAN 01, 1994 to MAR 29, 1994	Type of Visit: ALL	Service
Category: ALL		
Location of Encounter: ALL	Clinic: ALL	Sex of
Patient: BOTH		
Primary Provider: ALL	Purpose of Visits: Primary and	
Secondary		

AGE GROUPS

ICD Code	ICD Narrative	0-0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	TOTAL
250.00	DIABETES UNCO	.	.	.	.	5	20	45	30	100
401.9	HYPERTENSION	.	.	.	.	5	20	45	30	100
669.70	CESAREAN DELIV	.	.	.	.	2	1	.	.	3
818.0	FX ARM MULT/NOS	.	.	.	.	5	20	45	30	100
TOTAL		.	.	.	.	17	61	135	90	303



\*\*\*\*\* DIAGNOSES TALLY BY COMMUNITY/FACILITY \*\*\*\*\*  
 Jan 01, 1995 to Jan 15, 1995  
 COMMUNITY: SELLS

INPATIENT DIAGNOSES

SAN XAVIER HEALTH CENTER	SELLS HOSPITAL/CLINIC	PHOENIX IND MED CTR FAC
DIAGNOSIS/POV (ICD CODES)	DIAGNOSIS/POV (ICD CODES)	DIAGNOSIS/POV (ICD CODES)
DM UNCOMPL/T-II/NIDD (250.00) 5	HYPERTENSION NOS (401.9) 4	ACUTE URI NOS (465.9) 2
TOBACCO USE DISORDER (305.1) 2	CLOSED SKULL VAULT F (800.00) 2	BLOOD IN STOOL (578.1) 1
OLD LACERATION OF CE (622.3) 1	TRAUM ARTHROPATHY-UP (716.12) 1	DYSURIA (788.1) 1
URIN TRACT INFECTION (599.0) 1	HEADACHE (784.0) 1	RENAL COLIC (788.0) 1

INPATIENT MAJOR DIAGNOSTIC CATEGORIES

SAN XAVIER HEALTH CENTER	SELLS HOSPITAL/CLINIC	PHOENIX IND MED CTR FAC
DIAGNOSIS/POV (ICD CODES)	DIAGNOSIS/POV (ICD CODES)	DIAGNOSIS/POV (ICD CODES)
ENDOCRINE,NUTRIT,METABOLIC 5	NERVOUS SYSTEM 4	CIRCULATORY SYSTEM 4
KIDNEY & URINARY TRACT 3	HEALTH STATUS FACTORS 3	EAR, NOSE, MOUTH & THROAT 2
DIGESTIVE SYSTEM 1	MUSCULOSKELETAL & CONNECTIVE 1	
FEMALE REPRODUCTIVE SYSTEM 1		

RUN TIME (H.M.S): 0.0.28  
 End of report. HIT RETURN:

---

## FPRC    Frequency of Procedures Report

The Frequency of Procedures Report displays the most frequent diagnoses for a specified date range and selected visit criteria.

First, identify the visit date range and the number of most frequent diagnoses you want to display (for example, top 5 or top 10).

Next, if you would like a more specific report, you can select the visits to include by entering any combination of the data items in the list below. To select criteria, type "S" at the action prompt and press return. Then enter the numbers that correspond to the data items of interest. You can enter a list or range of numbers; e.g., 3,8,18-21,12. You will then be prompted to identify the specific parameters for each data item you selected, as applicable; for example, if you selected age, you would be prompted to enter an age range. When you have finished defining these parameters, you will be returned to the selection list. You can make any changes to your selections if needed, or type "Q" and press return to generate the report. Note that if you would like the report to include all visits within the specified date range, type "Q" at the action prompt and press return to bypass the visit selection screen.

### Visit Selection Criteria

- |                          |                             |                            |
|--------------------------|-----------------------------|----------------------------|
| 1) Name                  | 22) EDC Determination       | 42) Prim/Sec Prov Affil    |
| 2) Sex                   | 23) Last Menstrual Period   | 43) Diagnosis Code         |
| 3) Date of Birth         | 24) Time of Visit           | 44) Primary Dx (POV)       |
| 4) Age                   | 25) Type (IHS,638,etc.)     | 45) Stage of Dx (POV)      |
| 5) Date of Death         | 26) Service Category        | 46) Problem List Dx        |
| 6) Living Pts            | 27) Visit Location          | 47) Alcohol/Work Related   |
| 7) Chart Facility        | 28) Service Unit of Patient | 48) Cause of Dx (POV)      |
| 8) Community             | 29) Outside Location        | 49) Cause of Injury        |
| 9) Tribe                 | 30) Clinic Type             | 50) Place of Injury        |
| 10) Eligibility Status   | 31) Admitting Service       | 51) Operation Code         |
| 11) Beneficiary Class    | 32) Discharge Service       | 52) Dental ADA Codes       |
| 12) Medicare             | 33) Appt/Walk-In            | 53) Immunizations          |
| 13) Medicaid             | 34) Level of Service        | 54) Treatments Provided    |
| 14) Private Insurance    | 35) Eval&Management CPT     | 55) Lab Tests              |
| 15) Medicaid Plan Name   | 36) Length of Stay          | 56) Medications            |
| 16) Pvt Ins Plan Name    | 37) Primary Prov Name       | 57) CPT Code               |
| 17) Priv Ins Verified    | 38) Prim/Sec Prov Name      | 58) Exclude Inactive Pts   |
| 18) Desig Prim Care Prov | 39) Prim Prov Discipline    | 59) Inactive Patients      |
| 19) EDC                  | 40) Prim/Sec Prov Disc      | 60) Excl Incomplete Visits |
| 20) Date EDC Determined  | 41) Prim Prov Affil         | 61) Operating Provider     |
| 21) Contraception Method |                             |                            |

The following sample report includes all visits for September 1, 1994 to September 30, 1994. A cover page that lists the date range and selection criteria prints with each report.

---

---

\*\*\*\*\* FREQUENCY OF PROCEDURES REPORT \*\*\*\*\*

REPORT REQUESTED BY: BROWN,AMANDA

The following report contains a PCC Visit report based on the following criteria:

VISIT Selection Criteria

Encounter Date range: SEP 1, 1994 to SEP 30, 1994

ALL VISITS IN DATE RANGE SELECTED.

Total COUNT of Visits: 43

\*\*\*\*\* FREQUENCY OF PROCEDURES REPORT \*\*\*\*\*

Starting date: SEP 1,1994 Ending date: SEP 30,1994

No. VISITs: 43 No. PROCEDURES: 43 PROCEDURE/VISIT ratio: 1.00

TOP 10 PRC's =>

1. LARYNX CYST MARSUPIALIZ (10)
2. OTHER HERNIA REPAIR (9)
3. REMOVE HEAD/NECK SUTURES (8)
4. SPINAL TAP (5)
5. OTITIS MEDIA NOS (4)
6. APPENDECTOMY (4)
7. ARTHROT PROS REMOV NOS (3)

---

---

**Estimated Run Time:** Run time is a function of the date range selected and may be lengthy. Please contact your local Site Manager with questions about queuing this report.

## PAPC Purpose of Visits Grouped by APC Codes

This report provides a count of Purposes of Visits categorized by APC recode for a selected visit date range. You may restrict the count to residents of a selected Community. Within APC recode, you may choose to subtotal the counts by ICD Code.

You must enter starting and ending visit dates, a specific Community of Residence (ignored if not specified), and the maximum number of ICD POVs to include in each APC category for subtotalling. If you enter "0" for the maximum number of ICD POVs for each APC category, the report displays counts by APC recode only.

Included in this report are all visits that have a service category of Ambulatory. Contract and VA visits are excluded.

SAN XAVIER HEALTH CENTER

FEB 6,1995

Page 1

POV Counts for Ambulatory Visits from SEP 1,1994 through SEP 30,1994.  
ICD9 Subcounts are restricted to the leading 3 Purposes of Visit.

APC	APC Category	Count
300	UPPER RESPIRATORY INFECTION	7
	ICD9 ICD9 Description	
	-----	
	465.9 ACUTE URI NOS	6
	460. ACUTE NASOPHARYNGITIS	1
827	OTHER PROBLEMS	6
	ICD9 ICD9 Description	
	-----	
	V68.1 ISSUE REPEAT PRESCRIPT	3
	V65.4 COUNSELING NEC	2
	V64.0 NO VACCIN/CONTRAINDICAT	1
283	HYPERTENSIVE DISEASE	5
	ICD9 ICD9 Description	
	-----	
	401.9 HYPERTENSION NOS	5
819	PREVENTIVE HEALTH SERVICE	
	ICD9 ICD9 Description	
	-----	
	V72.2 DENTAL EXAMINATION	4
	V07.9 PROPHYLACTIC MEASURE NOS	1

**Estimated Run Time:** Run time is a function of the date range selected and may be lengthy. Please contact your local Site Manager with questions about queuing this report.

## TEN Frequency of Diagnoses Report

The Frequency of Diagnoses Report displays the most frequent diagnoses for a specified visit date range and selected visit criteria.

First, identify the visit date range and the number of most frequent diagnoses to display (for example, top 5 or top 10).

Next, if you would like a more specific report, you can select the visits to include by entering any combination of the data items in the list below. To select criteria, type "S" at the action prompt and press return. Then enter the numbers that correspond to the data items of interest. You can enter a list or range of numbers; e.g., 3,8,18-21,12. You will then be prompted to identify the specific parameters for each data item you selected, as applicable; for example, if you selected age, you would be prompted to enter an age range. When you have finished defining these parameters, you will be returned to the selection list. You can make any changes to your selections if needed, or type "Q" and press return to generate the report. Note that if you would like the report to include all visits within the specified date range, type "Q" at the action prompt and press return to bypass the visit selection screen.

### Visit Selection Criteria

- |                          |                             |                            |
|--------------------------|-----------------------------|----------------------------|
| 1) Name                  | 22) EDC Determination       | 42) Prim/Sec Prov Affil    |
| 2) Sex                   | 23) Last Menstrual Period   | 43) Diagnosis Code         |
| 3) Date of Birth         | 24) Time of Visit           | 44) Primary Dx (POV)       |
| 4) Age                   | 25) Type (IHS,638,etc.)     | 45) Stage of Dx (POV)      |
| 5) Date of Death         | 26) Service Category        | 46) Problem List Dx        |
| 6) Living Pts            | 27) Visit Location          | 47) Alcohol/Work Related   |
| 7) Chart Facility        | 28) Service Unit of Patient | 48) Cause of Dx (POV)      |
| 8) Community             | 29) Outside Location        | 49) Cause of Injury        |
| 9) Tribe                 | 30) Clinic Type             | 50) Place of Injury        |
| 10) Eligibility Status   | 31) Admitting Service       | 51) Operation Code         |
| 11) Beneficiary Class    | 32) Discharge Service       | 52) Dental ADA Codes       |
| 12) Medicare             | 33) Appt/Walk-In            | 53) Immunizations          |
| 13) Medicaid             | 34) Level of Service        | 54) Treatments Provided    |
| 14) Private Insurance    | 35) Eval&Management CPT     | 55) Lab Tests              |
| 15) Medicaid Plan Name   | 36) Length of Stay          | 56) Medications            |
| 16) Pvt Ins Plan Name    | 37) Primary Prov Name       | 57) CPT Code               |
| 17) Priv Ins Verified    | 38) Prim/Sec Prov Name      | 58) Exclude Inactive Pts   |
| 18) Desig Prim Care Prov | 39) Prim Prov Discipline    | 59) Inactive Patients      |
| 19) EDC                  | 40) Prim/Sec Prov Disc      | 60) Excl Incomplete Visits |
| 20) Date EDC Determined  | 41) Prim Prov Affil         | 61) Operating Provider     |
| 21) Contraception Method |                             |                            |

You will then be presented with the option of including only primary purposes of visits or all purposes of visits in the report. Finally, you will select the output type. You can choose a list format or a bar graph.

**Note:** If you choose to print a bar graph, you must print the report on 132-column paper.

---

The following sample report in list format includes all visits from June 29, 1994 to September 27, 1994. Each report includes a cover page that prints the date range entered and the visit selection criteria.

---

\*\*\*\*\* FREQUENCY OF DIAGNOSES REPORT \*\*\*\*\*

REPORT REQUESTED BY: BROWN,AMANDA

The following report contains a PCC Visit report based on the following criteria:

VISIT Selection Criteria

Encounter Date range: JUN 29, 1994 to SEP 27, 1994

ALL VISITS IN DATE RANGE SELECTED.

ALL (Primary and Secondary) POV's included.

Total COUNT of Visits: 122

\*\*\*\*\* FREQUENCY OF DIAGNOSES REPORT \*\*\*\*\*

Starting date: SEP 1,1994                      Ending date: SEP 30,1994

No. VISITs: 82      No. POV's: 122      POV/VISIT ratio: 1.49 (min. std. > 1.6)

TOP 10 POV's =>

1. ACUTE URI NOS (10)
2. DIABETES UNCOMPL ADULT/NIDDM (9)
3. NONINF GASTROENTERIT NEC (8)
4. HYPERTENSION NOS (5)
5. OTITIS MEDIA NOS (4)
6. DENTAL EXAMINATION (4)
7. SINGLE LIVEBORN-IN HOSP (3)
8. ISSUE REPEAT PRESCRIPT (3)
9. HYPOVOLEMIA (2)
10. CHRONIC SINUSITIS NOS (2)

TOP 10 DIAGNOSTIC CATEGORIES =>

1. EAR, NOSE & THROAT (19)
2. HEALTH STATUS FACTORS (18)
3. SKIN,BREAST,SUBCUTANEOUS T (15)
4. DIGESTIVE SYSTEM (14)
5. ENDOCRINE,NUTRIT,METABOLIC (11)
6. EYE (9)
7. CIRCULATORY SYSTEM (7)
8. MUSCULOSKELETAL & CONNECTIVE T (6)
9. PREGNANCY,CHLDBRTH,PUERPERIUM (6)
10. NEWBORNS & NEONATES (6)

---

**Estimated Run Time:** Run time is a function of the date range selected and may be lengthy. Please contact your local Site Manager with questions about queuing this report.

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## IMM    Immunization Reports

The following immunization reports are available from the Immunization Report menu. These reports address the immunization needs of the adults and children at your facility.

```
*****
**      PCC Management Reports      **
**      Immunization Report Menu    **
*****
          Version 3.0

          SELLS HOSPITAL/CLINIC

AIN      Adult Immunization Needs
KNIR     Kids Not on Immunization Register
```

## AIN Adult Immunization Needs

This report displays the most recent Td, Pneumococcal, and Influenza Vaccinations for Adults considered to be at high risk. Prior to running this report, you must use Q-Man to create a cohort (template) of patients to search. Developing a cohort of high-risk adults typically consists of selecting living patients who are over age 65 or who have one or more specific chronic diseases.

The following sample report was generated using a search template of patients over 65 years old.

SELLS HOSPITAL/CLINIC				Apr 10, 1996		Page 1
*****		ADULT IMMUNIZATION NEEDS		*****		
PATIENT NAME	SELLS NUMBER	COMMUNITY	AGE	LAST Td	LAST FLU	LAST PNEUMOVAX
THATCHER, STEPHEN	60091	AJO	80			
WINKERBEAN, ALLISON	101387	AKCHIN	71	10/22/85	10/24/89	
CARPENTER, LAURA	100089	ARTESA	65			
BURR, JOANNE	100185	BIG FIELDS	76	06/19/86		06/19/86
BUSH, JUSTIN	102779	BIG FIELDS	75		10/25/89	08/14/87
JONES, TANYA	100902	CHUICHU	77		11/28/89	11/28/89
GREENJEANS, BERTHA	101459	PISINIMO	68	05/29/86		05/29/86
CARTER, JULIE	100061	RIPLEY	68			
ROBERTS, FLORENCE	102494	SAN MIGUEL	94	12/20/89	10/20/88	
CARTER, AMANDA	101136	SAN PEDRO	68	07/15/85	10/25/89	09/24/86
THATCHER, HENRY	102449	SAN PEDRO	67	10/22/86	01/14/87	
GRANT, DOREEN	100321	SAN SIMON	75	04/21/87	11/09/88	
WINKERBEAN, AMY	103131	SAN SIMON	68	04/12/85	10/20/89	11/17/86
WINKERBEAN, PRISCILLA		SAN XAVIER	70		11/01/89	
BURR, THOMAS	102880	SANTA ROSA	90		10/27/87	
RUBBLE, BETH	100823	SANTA ROSA	74	12/30/88	12/30/88	
GREEN, DANIEL	101786	SELLS	74		11/16/88	
SMITH, GINA	102369	SELLS	79	01/31/90	11/03/89	10/02/85
SMITH, WALLY	102854	SELLS	72	08/31/87	10/28/88	04/14/89
WHEELWRIGHT, GRETCHEN	102331	SELLS	69	04/04/89	10/25/89	
SMITH, VERONICA	100332	TOPAWA	77		10/25/89	10/13/88
THATCHER, ROGER	102810	TOPAWA	79	01/20/86		01/09/90
VON BRAUN, JUSTIN	60005	TOPAWA	82			
BROEN, LAVERNE	102151	VAMORI	72	08/07/86	11/01/89	07/15/87
JEFFERSON, LISA	102826	VAMORI	68	09/15/88	12/14/87	
MUSTARD, LENORE	100775	VAMORI	90		12/15/89	11/16/87

End of report. HIT RETURN:

---

## KNIR Kids Not on Immunization Register

This report lists all children in a specified age range who are not in the immunization register. You will enter an age range and select a particular community, a group of communities, or all communities.

The sample report below shows children ages 5 to 8 in the Achi and Ajo communities who are not on the immunization register.

---

WARNING: CONFIDENTIAL PATIENT INFORMATION, PRIVACY ACT APPLIES

SELLS HOSPITAL/CLINIC

Apr 10, 1996 Page 1

\*\*\*\*\* CHILDREN NOT ON IMMUNIZATION REGISTER \*\*\*\*\*

Community: ACHI

-----

HANCOCK, JOE	(101987)	Aug 02, 1989	6 Years	MALE
		Nov 09, 1989	1 DPT, 1 OPV	
		Jan 11, 1990	2 DPT, 2 OPV	
WATERMAN, REBECCA	(101884)	Jul 09, 1988	7 Years	FEMALE
		Aug 18, 1988	1 DPT, 1 OPV	
		Nov 21, 1988	2 DPT, 2 OPV	
		Jan 12, 1989	3 DPT, 3 OPV	
		Nov 09, 1989	MEASLES, RUBELLA, MUMPS, 1 MMR	
		Jan 11, 1990	4 DPT, 4 OPV, HIB PRP-CRM	

Community: AJO

-----

BROWN, RUTH	(60146)	Jul 01, 1987	8 Years	FEMALE
		No prior immunizations listed		
BURR, CURT	(102003)	Sep 12, 1989	6 Years	MALE
		Feb 07, 1990	1 DPT, 1 OPV	
LINCOLN, NORMAN	(102027)	Dec 02, 1989	6 Years	MALE
		Jan 11, 1990	1 DPT, 1 OPV	

---

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## DR PCC Patient Data Retrieval Utility

This utility uses scripts to retrieve patient information from the PCC. Upon entering this option you will be asked for a patient's name. You will enter a script to retrieve patient clinical or demographic information.

### SCRIPT CREATION

A script is an instruction to the PCC Data Retrieval Utility to obtain patient information from the PCC database. Both demographic and clinical information may be retrieved for a patient.

#### Demographic Data

To obtain demographic data for a patient, the first word you enter must be either PT or PATIENT. Then enter the type of information you desire. If the text you enter is ambiguous, you will not receive a value in return. For example, you may enter the following:

- PT NAME
- PT CURRENT COMMUNITY
- PT AGE
- PT DOB
- PT TRIBE OF MEM

This above list includes patient demographic data items that are most frequently requested. You may ask for other demographic information as well.

#### Clinical Data

Scripts may be used to retrieve clinical data. The following sample scripts show some of the types of information you can retrieve from the PCC database.

---

```
LAST 3 MEAS BP;DURING 1991 - RETURNS LAST 3 BLOOD PRESSURES  
                             TAKEN DURING 1991  
LAB GLUCOSE;ON SEP 3, 1992 - RETURNS ALL GLUCOSES TAKEN ON  
                             SEPT 3, 1992  
FIRST ACTIVE.PROBLEM - RETURNS FIRST ACTIVE PROBLEM FROM THE  
                       PROBLEM LIST; DATE DETERMINED BY DATE  
                       ENTERED OR LAST MODIFIED  
LAST IMMUN PNEUMOVAX - RETURNS LAST PNEUMOVAX GIVEN
```

---

The script on the previous page can be broken down into its four component parts for further explanation. LAST 3 MEAS BP; DURING 1991 will be used for this example.

- LAST 3** - Limits occurrences; use first, last, or all.
  - Can indicate number of instances.
  - Optional; if not used system will default to 'all.'
- MEAS** - Data Class; i.e., AS LABS, POV, ADA.CODE.
- BP** - Optional; what you are looking for within the data class
  - If not indicated, system will look at all values within data class.
- DURING 1991** - Optional use of date parameters.

These four components are explained in detail below.

### **Limiting Occurrences: Use of First, Last, and All**

The first word of the script must be either FIRST, LAST, or ALL. If FIRST, LAST, or ALL is not entered, then the system will assume you mean ALL. You may specify the number of occurrences for which a particular value should be retrieved; for example, FIRST 3 or LAST 2.

### **Data Class**

The second word in the script can be LAB, RX, ADA.CODE, EXAM, VISIT, POV, MEASUREMENT, PROCEDURES, SKIN.TEST, IMMUNIZATION, RADIOLOGY, EDUCATION, ACTIVE.PROB, INACTIVE.PROB, FAMILY.HISTORY, PERSONAL.HISTORY, or HEALTH.FACTORS. The second word is known as the data class. If the data class has more than one word, each word must be separated by a period when entered into the script; for example, ADA.CODE. However, you do not have to enter a second word for any of the scripts because the first word is enough for the data retriever to know what class you are selecting. Many of the classes, such as DENTAL SERVICES and MEDICATIONS, have acronyms. In most instances, you need only enter the first few identifying characters of a data class. For instance, if you wanted to specify ACTIVE PROBLEMS, you may enter ACT instead of spelling it out. The data retriever would recognize these three letters as ACTIVE PROBLEMS.

### **Value within the Data Class**

The third word is the value, or what you are looking for, within the data class. For example, the value would be a lab test for labs and an ADA CODE for dental services. Also, instead of entering an ICD9 code, you may enter a narrative such as DIABETES or DM.

### **Date Parameters**

You may restrict the date range from which to retrieve patient information by placing a semicolon (;) at the end of the script followed by a restriction on the date, such as on, equals, before, during, between, or a symbol (>, <, <>, =). You may then enter an exact date or a range of dates by placing a dash (-) between the two dates. Dates must be in standard fileman format. You may enter the month and year or year only in addition to full dates. (See the sample scripts on the following page for examples of entering date parameters.)

---

## Taxonomy Creation

If an asterisk (\*) is entered for the value within the data class, you will be asked for multiple values associated with the selected data class. You could then enter a range of ICD9 codes for POVs or multiple ADA CODES, for example. Not all data classes allow entry of more than one value. Available data classes for taxonomy creation are: diagnosis, ADA code, RX, procedure (medical), patient education topic, and health factors. You may store these multiple values in a taxonomy, if you choose. Then you may enter the name of the taxonomy prefaced by a left square bracket ([) as an indication of the desired values to be retrieved.

The following report shows the data received from the sample script.

---

```

Select PATIENT NAME:      WATERMAN,RAE JESSICANN
                           F 11-10-70 532380546   SE 333333

ENTER SCRIPT:  LAST 3 MEAS BP

VISIT DATE: 06/23/1993   VALUE: 120/90       TYPE: BP
VISIT DATE: 03/04/1993   VALUE: 100/80       TYPE: BP
VISIT DATE: 08/25/1992   VALUE: 120/80       TYPE: BP

ENTER SCRIPT:  LAST VISIT

VISIT DATE: 08/02/1993   VALUE: VISIT

ENTER SCRIPT:  LAST POV DM
250.00 (DIABETES UNCOMPL TYPE II/NIDDM)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NONINSULIN
DEPENDENT/ADULT-ONSET

OK? Y//

VISIT DATE: 07/19/1993   VALUE: 250.00

```

---

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## RT Report Template Utility

This utility is used to create a report of individual patient demographic and clinical information. You create a word-processing-type document that embeds patient data within user-specified locations throughout the report. The patient data is retrieved through scripts or natural language queries that identify the requested patient information.

```
*****
**   PCC Management Reports   **
**       Report Template     **
*****
          Version 3.0

          SELLS HOSPITAL/CLINIC

CR      Create Report Template
MD      Modify/Delete Report Template
PR      Print Report Template
TC      Taxonomy Creation For A Script

Select Report Template Utility Option:
```

---

## Creation of Report Templates

The report template is a word-processing-type document that you create using File Manager tools. You need to know how to use the editor in File Manager in order to create the report template. First, select the Create Report Template option on the Report Template menu. Use this option only to **create** new report templates. Use the Modify/Delete option for editing previously created templates. You must name the report then enter a description, if desired. Finally, you will create the report template itself and enter information about each parameter in the report template.

---

```
Select Report Template Utility Option: CR Create Report Template
ENTER THE NAME OF A NEW REPORT TEMPLATE: DIABETIC AUDIT
ARE YOU ADDING 'DIABETIC AUDIT' AS A NEW REPORT TEMPLATE (THE 3RD)? Y (YES)
NAME: DIABETIC AUDIT//
DESCRIPTION:
1>This report will print several items of an important clinical nature
2>regarding diabetic patients and their current care.
3>
EDIT Option:
```

---

## 1 Writing the Report

The report is entered within the TEMPLATE field. The final report will look exactly the same as the way it was entered into the TEMPLATE field. You may need to calculate the length of each data item entered so that the line length does not extend beyond the right margin of the report. If it does, the line will wrap to the next line. If the line extends beyond 245 characters, you will see '...etc.' that indicates there was more data to print, but there was not enough room to do so. You may modify the report so that the data prints on each line. As you create reports, this task will become easier as you gain more experience with the software. In the example below, the numbers within the vertical bars represent data that you would like printed in the report at run time. Each windowed number ( |3| ) is a report parameter, representing where patient data is to be inserted. Parameters are described in detail on the next page.

---

```
TEMPLATE:
1>PATIENT NAME: |1| AGE: |2| DOB: |3|
2>
3>LAST VISIT FOR DIABETES: |4|
4>LAST VISIT FOR HYPERTENSION: |5|
5>TOBACCO USE: |6|
6>LAST WT: |7| LAST HT: |8|
7>
8>LAST RX INSULIN: |9|
9>LAST RX ORAL HYPOGLYCEMIC: |10|
10>LAST BLOOD SUGAR: |11|
```

---

If you decide that it would be useful to have the patient's current community and tribe inserted within the report, you may modify the report using the editor to insert a line (see example below). You may add, change, or delete lines *ad infinitum* until the report output is exactly what you want.

---

```

EDIT Option: Insert after line: 1
1>PATIENT NAME: |1|          AGE: |2|          DOB: |3|
2>CURRENT COMMUNITY: |12|    TRIBE: |13|
3>
4>
2 lines inserted.....
EDIT Option:

```

---

**Note:** On long reports, you can insert page breaks. To do so, type the “at” character ( @ ) on a line to indicate to the report writer to start a new page. This must be the only character on the line and it must be in the first column. Inserting a page break in the sample on page 148 would look as follows:

---

```

9>LAST RX ORAL HYPOGLYCEMIC: |10|
10>LAST BLOOD SUGAR: |11|
EDIT Option: Insert after line: 10
9>LAST RX ORAL HYPOGLYCEMIC: |10|
10>LAST BLOOD SUGAR: |11|
11>@
12>

```

---

In the above example, since the page break was placed at the bottom of the report, each patient's report will appear on a separate page.

## 2 Parameters

The term *parameter* describes the piece of data to be inserted within a word-processing document; i.e., the report template. Each parameter has a unique number. The parameter number that you enter within the report is the same number that you enter when you see the PARAMETER: prompt while creating the report template. You will then be asked for a description of the parameter. Although optional, it is a good idea to enter a description to remind yourself what the number corresponds to in the report. Then you will be asked to enter a script. There is a separate user's manual that describes script creation in detail when utilizing the data retrieval option on the PCC Management Reports menu. A brief description of script creation for report templates follows this section on parameters.

The |1| means parameter number 1. Enter the number of the parameter between two vertical bars ( |1| ) where you would like it to appear in you document. You may put more than one parameter on a line and may include text before or after the parameter, if desired. For example:  
 FIRST LAB GLUCOSE: |2| LAST PROCEDURE: |3||4| (CIRCLE IF GLUCOSE > 200)

The text CIRCLE IF GLUCOSE > 200 may be an instruction to the reviewer of the report. If many occurrences of a particular test or diagnosis are requested, for example, LAST 15, the line will not be broken and will appear as a continuous line (no wrap). If the length of the line is more than 245 characters, you will see '... etc.' printed to indicate that other pieces of information were retrieved but could not be printed in the allotted space.

Data is embedded in the report through the use of parameters. The parameters for the above report are created in the following sample.

---

---

```
Select PARAMETER: 1
  PARAMETER DESCRIPTION:
  1>PATIENT NAME
  2>
EDIT Option:
  PCC SCRIPT: PT NAME
Select PARAMETER: 2
  PARAMETER DESCRIPTION:
  1>PATIENT AGE
  2>
EDIT Option:
  PCC SCRIPT: PT AGE
Select PARAMETER: 3
  PARAMETER DESCRIPTION:
  1>PATIENT DOB
  2>
EDIT Option:
  PCC SCRIPT: PT DOB
Select PARAMETER: 12
  PARAMETER DESCRIPTION:
  1>CURRENT COMMUNITY
  2>
EDIT Option:
  PCC SCRIPT: PT CURRENT COMMUNITY
Select PARAMETER: 13
  PARAMETER DESCRIPTION:
  1>TRIBE OF MEMBERSHIP
  2>
EDIT Option:
  PCC SCRIPT: PT TRIBE OF MEMBERSHIP
Select PARAMETER: 4
  PARAMETER DESCRIPTION:
  1>LAST VISIT FOR DIABETES
  2>
EDIT Option:
  PCC SCRIPT: LAST DX [SURVEILLANCE DIABETES
```

---

---

Let's stop here for a moment to review what [SURVEILLANCE DIABETES in the preceding report means. The left square bracket indicates that a taxonomy is to be used. A taxonomy is a group of related values, such as various kinds of nonsteroidal anti-inflammatory medication or all ICD9 codes relating to a particular disease. SURVEILLANCE DIABETES is the name assigned to the taxonomy we want used in this script. In this case, it refers to a range of ICD9 codes (250.00-250.93) that the PCC Data Retrieval Utility will look for when searching for a patient's last diabetes diagnosis. (See page 155 for creating taxonomies to use within PCC scripts.)

---

```
Select PARAMETER: 5
  PARAMETER DESCRIPTION:
  1>LAST VISIT FOR HYPERTENSION
  2>
EDIT Option:
  PCC SCRIPT: LAST DX [SURVEILLANCE HYPERTENSION
Select PARAMETER: 6
  PARAMETER DESCRIPTION:
  1>TOBACCO USAGE
  2>
EDIT Option:
  PCC SCRIPT: LAST HEALTH [TOBACCO
Select PARAMETER: 7
  PARAMETER DESCRIPTION:
  1>LAST WT
  2>
EDIT Option:
  PCC SCRIPT: VALUE LAST MEAS WT
Select PARAMETER: 8
  PARAMETER DESCRIPTION:
  1>LAST HT
  2>
EDIT Option:
  PCC SCRIPT: LAST MEAS HT
Select PARAMETER: 9
  PARAMETER DESCRIPTION:
  1>LAST RX FOR INSULIN
  2>
EDIT Option:
  PCC SCRIPT: DATE LAST RX [DM AUDIT INSULIN DRUGS
Select PARAMETER: 10
  PARAMETER DESCRIPTION:
  1>LAST RX FOR ORAL HYPOGLYCEMICS
  2>
EDIT Option:
  PCC SCRIPT: LAST RX [DM AUDIT ORAL HYPOGLYCEMICS
Select PARAMETER: 11
  PARAMETER DESCRIPTION:
  1>LAST BLOOD SUGAR
  2>
EDIT Option:
  PCC SCRIPT: LAST LAB GLUCOSE
```

---

### 3 Scripts

The script you create will be utilized by the PCC Data Retrieval Utility. Please refer to the section on the PCC Data Retrieval Utility in this manual for a description of how to create scripts. This section describes the restrictions on script creation (as compared to script creation when utilizing the PCC Data Retrieval Utility) and an added feature for using scripts to support report template parameters.

There are two restrictions on script creation:

1. Do not enter an asterisk (\*) as a value with the intention of creating a taxonomy. Although this character is acceptable when utilizing the PCC Data Retrieval Utility, you cannot use it within a report template script. Instead, create a taxonomy via the option located on the report template menu.
2. You will not be able to append a range of visit dates to the end of the script. You will indicate the range of visit dates when selecting the Print Report Template option.

The additional feature available when using scripts within the Report Template Utility is the use of the words DATE and VALUE to preface a script that pertains to clinical information.

We will use the script LAST 3 LAB GLUCOSE as an example of how to use this feature. If you entered the script as written, the last three glucose values and the dates on which the values were obtained would be printed. If you preface the script with the word DATE (DATE LAST 3 LAB GLUCOSE), only the date of each glucose will be printed on the report. If you preface the script with the word VALUE (VALUE LAST 3 LAB GLUCOSE), only the value for each glucose will be printed on the report. In the report template used in this section (page 151), look at parameters 8 and 10 to see how VALUE and DATE can be used in the design of a report.

---

## Modifying a Report Template

The report can now be modified by inserting a heading at the top. You can also add and remove parameters from the report template or modify parameter descriptions and PCC scripts.

---

Select Report Template Utility Option: **MD** Modify/Delete Report Template

Select REPORT TEMPLATE NAME: **DIABETES PROGRAM QA AUDIT**

NAME: DIABETIC AUDIT//

DESCRIPTION:

- 1>This report will print several items of an important clinical nature
- 2>regarding diabetic patients and their current care.

EDIT Option: .....

TEMPLATE:. . .

6>

7>LAST VISIT FOR DIABETES: |4|

8>LAST VISIT FOR HYPERTENSION: |5|

9>TOBACCO USE: |6|

10>LAST WT: |7|            LAST HT: |8|

11>

12>LAST RX INSULIN: |9|

13>LAST RX ORAL HYPOGLYCEMIC: |10|

14>LAST BLOOD SUGAR: |11|

EDIT Option: Insert after line: **0**

1>**DIABETIC AUDIT REPORT**

2>

3>

2 lines inserted.....

EDIT Option: List line: 1// to: 13//

1>DIABETIC AUDIT REPORT

2>

3>PATIENT NAME: |1|            AGE: |2|            DOB: |3|

4>CURRENT COMMUNITY: |12|        TRIBE: |13|

5>

6>LAST VISIT FOR DIABETES: |4|

7>LAST VISIT FOR HYPERTENSION: |5|

8>TOBACCO USE: |6|

9>LAST WT: |7|            LAST HT: |8|

10>

11>LAST RX INSULIN: |9|

12>LAST RX ORAL HYPOGLYCEMIC: |10|

13>LAST BLOOD SUGAR: |11|

EDIT Option:

Select PARAMETER: 1

PARAMETER: 1//^

---

---

## Printing the Report

You will be asked to enter either the fiscal year or range of dates during which the patient's visits occurred. The PCC scripts for each parameter that pertains to clinical information will look **only** at medical data that was generated for that patient during the indicated date range. An example is a script that reads LAST 3 LAB GLUCOSE. The last 3 lab glucoses obtained during the indicated range of visit dates would be printed. If a particular piece of patient data is not indicated in the patient's medical record during the specified time frame, the words "None Found" will appear in place of the requested data.

---

---

Select Report Template Utility Option: **PR** Print Report  
Select REPORT TEMPLATE NAME: **DIABETIC AUDIT** ADAM, ADAM

Select one of the following:

- 1 Fiscal Year
- 2 Date Range

Indicate the desired time frame: **1** Fiscal Year

Enter report fiscal year: **1992**  
Enter patient or [search template name: **WATERMAN,RAE JESSICANN**  
Enter patient or [search template name:  
DEVICE: HOME//

### DIABETIC AUDIT REPORT

PATIENT NAME: WATERMAN,RAE JESSICANN AGE:22 DOB: NOV 10, 1970  
CURRENT COMMUNITY: TUCSON  
TRIBE: TOHONO O'ODHAM NATION OF ARIZONA

LAST VISIT FOR DIABETES: 250.00 - 08/25/92  
LAST VISIT FOR HYPERTENSION: 401.9 - 08/25/92  
TOBACCO USE: None Found  
LAST WT: 200 LAST HT: 5/5/92

LAST RX INSULIN: INSULIN NPH U-100 (BEEF) - 07/07/92  
LAST RX ORAL HYPOGLYCEMIC: None Found  
LAST BLOOD SUGAR: 120 - 07/07/92

---

---

The following example indicates how to enter one or more search templates (place a left square bracket before the name of your search template) and/or individual patients. Only search templates that store patients within it will be accepted.

---

---

Enter patient or [search template name: **[MY PTS** (FEB 11, 1993) FILE 2  
Enter patient or [search template name: **WHEELWRIGHT,MANDY**  
F 04-03-87 123323333 SX 100007  
Enter patient or [search template name:  
DEVICE: HOME// **72** COMPUTER RM - PRINTRONIX RIGHT MARGIN: 80//

---

---

---

## Creating Taxonomies for Use within Report Templates

Taxonomies are groups of related values, such as all ICD9 codes for diabetes or all antibiotics. You can use this option to create taxonomies for use in PCC SCRIPTS as well as Q-Man. A more complete discussion on how to create a taxonomy can be found within Volume I of the Q-Man user documentation. You can create taxonomies for use in PCC SCRIPTS only for the listed attributes.

---

Select Report Template Utility Option: **TC** Taxonomy Creation For A Script

Select one of the following:

- |   |                     |
|---|---------------------|
| 1 | DIAGNOSIS           |
| 2 | ADA CODE            |
| 3 | RX                  |
| 4 | PROCEDURE (MEDICAL) |
| 5 | PATIENT ED TOPIC    |
| 6 | HEALTH FACTORS      |

Enter response: **6** HEALTH FACTORS

Enter HEALTH FACTOR: **???**

CHOOSE FROM:

CURRENT SMOKELESS  
 CURRENT SMOKER  
 NON-TOBACCO USER  
 PREVIOUS SMOKELESS  
 PREVIOUS SMOKER

Enter HEALTH FACTOR: **CURRENT SMOKELESS**

Enter ANOTHER HEALTH FACTOR: **CURRENT SMOKER**

Enter ANOTHER HEALTH FACTOR: **NON-TOBACCO USER**

Enter ANOTHER HEALTH FACTOR: **PREVIOUS SMOKER**

Enter ANOTHER HEALTH FACTOR: **PREVIOUS SMOKELESS**

Enter ANOTHER HEALTH FACTOR:

The following have been selected =>

NON-TOBACCO USER  
 CURRENT SMOKER  
 CURRENT SMOKELESS  
 PREVIOUS SMOKER  
 PREVIOUS SMOKELESS

Want to save this HEALTH FACTOR group for future use? NO// **Y** (YES)

Group name: **TOBACCO**

ARE YOU ADDING 'TOBACCO' AS A NEW TAXONOMY (THE 27TH)? **Y** (YES)

TAXONOMY BRIEF DESCRIPTION: **SMOKING RELATED HEALTH FACTORS**

EXTENDED DESCRIPTION:

1>

---

## A PROGRAMMER'S GUIDE TO THE REPORT TEMPLATE UTILITY

### Introduction

The Report Template Utility (RTU) is used to create a report with patient demographic and clinical information or with any data you may want imbedded within a canned report. The developer creates a word-processing-type document that embeds patient data within programmer-specified locations throughout the report (analogous to the BULLETIN system). There are two ways to retrieve the data for incorporation into the report. One way is to retrieve patient data via the creation of scripts or natural language queries. For details, you will need to read the user and programmer documentation for the PCC Data Retrieval Utility, specifically the information regarding script creation. You may elect not to use the retrieval utility and instead retrieve data (from any source) via your own code and set the appropriate utility nodes (to be discussed later in this document) for use in a word-processing document stored in the Report Template file whose entries are used by the Report Template Utility.

The best place to start to understand how to interact with this software is the user's guide to the RTU. The programmer interface allows for retrieval of data from sources other than the PCC, for more complicated data retrievals from the PCC than allowed by the script mechanism (scripts may be used as well), and for storing data for each patient so that a cumulative report can be printed at the end of a user request for information regarding a cohort of patients.

The package comes with the IHS Diabetes Audit reports. You may want to look at the routines APCLDM\* to see how the RTU was utilized to generate the report for the patient and the cumulative report. Also, look at the entries for the two diabetic reports in the REPORT TEMPLATE file.

### Routines

There are two routines that allow interaction: APCLASK and APCLPRT.

#### APCLASK

This routine prompts you for a range of visit dates by which the data search is restricted. It also prompts you for one or more patients or search templates containing the DFNs of patients. It calls your routine to retrieve the patient data and then it calls APCLPRT to print the reports.

**APCLASK is to be called for the printing of patient data only.** As described in the following section, you may call APCLPRT directly to incorporate non-patient-related data into a report template.

APCLASK is called with the use of parameters. You can pass one or two values. The first parameter is the DFN of the entry in the REPORT TEMPLATE file that you want used by the RTU. The second parameter, which is optional, is the DFN of the cumulative report you would like printed. The first report is printed once for each patient requested by you. If a cumulative report is to be printed, it will print after the entire cohort of patients is printed. Cumulative data is discussed in more detail on the following page.

*Example 1:* SET var1=1,var2=2 D ^APCLASK(var1,var2)

For each patient, the report with DFN 1 will be printed. At the end of the data retrieval for all patients, the cumulative report, DFN 2, will be printed.

*Example 2:* SET var1=1 D ^APCLASK(var1)

Only the noncumulative report with a DFN of 1 will be printed for each patient.

How is the data for the report retrieved? The routine APCLASK will look at the entry requested in the REPORT TEMPLATE file to see if a value exists in the .03 ROUTINE field. This is the routine that will retrieve data for use in the word-processing document you created.

When you create a report template in the REPORT TEMPLATE file, enter the name of the routine that you want called by APCLASK in the .03 field. The variables that will be available to you for use in your data retrieval routine are as follows:

APCLPD	Patient DFN in VA PATIENT file
APCLDATE	Requested date range in the following format “DURING JAN 1 1991-DEC 31 1992”
APCLBDT	Beginning of date range in the following format: “MAY 16, 1993”
APCLEDT	End of date range in the same format

For a script such as LAST LAB GLUCOSE, your routine could call the data retrieval tool with the script written as LAST LAB GLUCOSE\_APCLDATE.

You **must** store the retrieved data for each parameter indicated in the word-processing document in the node ^TMP("APCL",\$J, n) for the noncumulative report and ^TMP("APCLCUML",\$J,n) for the cumulative report. The letter “n” corresponds to the number of the parameter within your report template.

The value of the cumulative nodes will normally be set to a fraction representing the number of patients who had a particular value; for example, 2/10 patients had a pneumovax during the past year. If you indicate in the TYPE field located within the PARAMETER multiple that a fractional value should be displayed as a percent, the report will print 20% rather than 2/10.

As a reminder, if you enter a @ on a line of its own in the report template, the report generator will generate a form feed and begin printing on the next page.

You need not call the routine APCLASK to utilize the RTU. You may call APCLPRT directly. You may want to do this when using your own user interface or when dealing with non-patient-related data.

## APCLPRT

This routine is also called with parameter passing. The first variable is the DFN of the report template to be utilized and the second variable is the root of the local or global variable used to store the data where the namespace is ABC. The DFN of the template to be used is 13.

The following is a sample report template (DFN 13), an array with the necessary data to be imbedded into the report (namespace is "ABC"), the call to APCLPRT, and the generated report.

*Template:*

An appointment has been scheduled for you to be seen in the |1| clinic.  
You have a follow-up visit for |2|. Your appointment is on  
|3| at |4|.

If there are any problems with keeping this appointment, please contact us at |5|.

*Array:*

```
SET ^TMP("ABCRPT1",$J,1)="Dental"  
SET ^TMP("ABCRPT1",$J,2)="an endodontic consultation"  
SET ^TMP("ABCRPT1",$J,3)="MAY 29, 1993"  
SET ^TMP("ABCRPT1",$J,4)="2:30PM"  
SET ^TMP("ABCRPT1",$J,5)="295-0010"
```

*Call to APCLPRT:*

```
SET ABCPDFN=13,ABCROOT="^TMP("ABCRPT1",$J  
D ^APCLPRT(ABCPDFN,ABCROOT)
```

*Output:*

An appointment has been scheduled for you to be seen in the Dental clinic.  
You have a follow-up visit for an endodontic consultation. Your appointment is on  
May 29, 1993 at 2:30PM.

If there are any problems with keeping this appointment, please contact us at 295-0010.



## STS Search Template System

This system has options that allow you to create search templates either through the FileMan Search option or manually. A search template comparison utility is also available, which permits you to match the contents of one FileMan search template with another. The STS provides the capability to delete and add entries to existing search templates that you have created. Also, you can access FileMan (General) from this menu.

**Note:** If you create a search template via the search template utility or the option that allows for manual creation of a search template, there will be no search logic associated with these templates. Search templates created via the FileMan Search option have search logic stored with them. This means that you can utilize this template's search logic within the search option of FileMan.

```
Search Template System
Version 2.5
Site Set To SELLS HOSP

SRCH Search Template Comparison Utility
CRE Create Search Template Manually
ADD Add Entries Into An Existing Search Template
DENT Delete Entries From An Existing Search Template
CNT Count Entries In A Search Template
SRT Inquire Into Sort/Search Template File
DEL Delete Search Template
SAVE Save Search Template
FGEN FileMan (General) ...

Select Search Template System Option:
```

A separate user's manual for the Search Template System that describes the use of this system in depth is available.

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## QMAN Q-Man (PCC Query Utility)

Q-Man (the PCC Query System) is a utility for “mining” the PCC database. It facilitates retrieval of demographic and clinical information.

```
***** Q-MAN OPTIONS *****

Select one of the following:

1      SEARCH PCC Database (dialogue interface)
2      FAST Facts (natural language interface)
3      RUN Search Logic
4      VIEW/DELETE Taxonomies and Search Templates
5      FILEMAN Print
9      HELP
0      EXIT

Your choice: SEARCH//
```

No special knowledge of MUMPS, FileMan, or the PCC file structure is required to use Q-Man. You generate a query by initiating a dialogue with the computer. Each query has a subject, attribute, condition, and value. For example, consider the following query:

```
"Find all patients over 60 years of age."
  SUBJECT = Patients
  ATTRIBUTE = Age
  CONDITION = Over
  VALUE = 60
```

Multiple queries can be “and’ed” together to define a search.

The output of the search is either a standard columnar display on the screen, a printed report, or a FileMan search template (i.e., a cohort of patients).

In addition to the dialogue interface described above, there is also a natural language interface to Q-Man. You can enter a simple (1 attribute only) query in English. Frequently, Q-Man will correctly interpret the query and print the results on the screen. If Q-Man does not understand the question, it will beep and ask you to try again. Sample queries for the Rapid Report option are:

```
"SHOW ME MARY MARTIN'S LAST BLOOD SUGAR"  
"FIND ALL PATIENTS WHO LIVE IN TUCSON"  
"SHOW ME EVERYONE WHOSE TRIBE OF MEMBERSHIP IS NAVAJO"  
"I WANT LISA JONES' AVERAGE WEIGHT"  
"NOW GET HER SSN"
```

Notice that the word AND does not appear in any of the queries and that all queries are quite simple. Try it. If it doesn't work for you, use the dialogue interface.

A separate Q-Man user's manual that describes the use of the Query System in depth is available.



## FM FileMan (General)

The FileMan utility is a set of retrieve-only options from the File Manager database management system. The menu contains the following options:

- |   |                         |
|---|-------------------------|
| 1 | Search File Entries     |
| 2 | Print File Entries      |
| 3 | Inquire to File Entries |
| 4 | Statistics              |
| 5 | List File Attributes    |

The Search and Print options allow you to create *ad hoc* reports. The Inquire option allows you to see entries within a file. The Statistics option is a menu that, when appropriate, allows the creation of a histogram or scattergram or gives basic mathematical statistics for a report that was generated by the Print or Search option. The Statistics menu options must be run just after the report is generated as results will not be saved once another report is printed. Note that the Statistics menu options cannot be used if a report is queued to a printer. List File Attributes displays the fields and attributes of those fields that make up a FileMan file. These make up what is referred to as the data dictionary of the file.

A separate File Manager user's manual that describes the use of these utilities in depth is available.

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## Appendix

### Statistical Database Record Definition

Record 1 of 2

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
RECORD CODE	1	2	2	Y	Will always be 00
SEQUENCE #	3	3	1	Y	Will always be 1
UNIQUE ID #	4	19	16	Y	Unique ID for this visit. ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DOB	32	38	7	Y	DOB in format 2960908. CYYMMDD
SEX	39	39	1	Y	Sex. M or F
SSN	40	48	9	Y	SSN of patient or 9 blanks. No dashes.
PRIMARY TRIBE	49	51	3	Y	Tribe code from standard code book.
COMMUNITY OF RESIDENCE	52	58	7	Y	STCTYCOM code of patient's residence. Taken from the current community field.
CLASSIFICATION /BENEFICIARY	59	60	2	Y	Beneficiary Code from Standard Code book.
ELIGIBILITY	61	61	1	Y	Eligibility Status from standard codebook.
MEDICAID ELIG ON VISIT DATE	62	62	1	Y	Y or N. If patient was Medicaid eligible on the visit date, this is set to Y, if not, N.
MEDICARE ELIG ON VISIT DATE	63	63	1	Y	Y or N. If patient was Medicare eligible on the visit date, this is set to Y, if not, N.
PRIVATE INSURANCE ELIGIBILITY ON VISIT DATE	64	64	1	Y	Y or N. If patient was Private Insurance eligible on the visit date, this is set to Y, if not, N.

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
VISIT/ ADMISSION DATE	65	71	7	Y	Date of Visit in CYMMDD format.
TIME OF DAY	72	75	4	Y	Time of day in internal FileMan format; e.g., 1000, 1310, 0805
DAY OF WEEK	76	76	1	Y	DOW in APC record definition format.
LOCATION OF ENCOUNTER	77	82	6	Y	ASUFAC of location of encounter.
TYPE	83	83	1	Y	Type of Visit. C, I, O, 6, T, U, V, S, etc.
SERVICE CATEGORY	84	85	2	Y	Service Category; e.g., A, H, I, C, T, etc.
CLINIC	86	87	2	N	Clinic of Visit, standard 2 digit code.
EVALUATION AND MANAGEMENT CPT CODE	88	92	5	N	CPT CODE from Evaluation and Management field of Visit file.
LEVEL OF SERVICE	93	93	1	N	Level of Service code from PCC form.
EDUCATION DONE OF THIS VISIT	94	94	1	N	Was an education topic provided on this visit? Y or N
EXAMS DONE ON THIS VISITQ	95	95	1	N	Was one or more exams done on this visit? Y or N
# OF LAB TESTS DONE	96	98	3	N	# of lab tests done.
# OF RX'S	99	100	2	N	# of prescriptions filled.
VITAL SIGNS DONE	101	101	1	N	Were vital signs taken? Y or N
PRIMARY PROV AFFILIATION/ DISCIPLINE	102	104	3	Y	Primary Provider's Affiliation and Discipline; e.g., 101
OTHER PROVIDER AFFILIATION/ DISCIPLINE	105	107	3	N	First Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	108	110	3	N	2nd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	111	113	3	N	3rd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	114	116	3	N	4th Secondary Provider Affiliation/Discipline.

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
PRIMARY ICD DX	117	122	6	Y	Primary ICD Dx. If this is a non-hospitalization visit, it is the 1st diagnosis entered.
APC CODE 1	123	125	3	Y	APC Recode for diagnosis 1
CAUSE OF DX 1	126	126	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 1
CAUSE OF INJURY	127	132	6	N	Valid ICD9 E code for an injury. If Diagnosis 1 is an injury 800-999.9.
PLACE OF INJURY	133	133	1	N	PCC place of injury code for Diagnosis 1 if Diagnosis 1 is an injury.
DIAGNOSIS 2	134	139	6	Y	ICD Dx 2. If this is a non-hospitalization visit, it is the 2nd diagnosis entered.
APC CODE 2	140	142	3	Y	APC Recode for diagnosis 2
CAUSE OF DX 2	143	143	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 2
CAUSE OF INJURY	144	149	6	N	Valid ICD9 E code for an injury. If Diagnosis 2 is an injury 800-999.9.
PLACE OF INJURY	150	150	1	N	PCC place of injury code for Diagnosis 2 if Diagnosis 2 is an injury.
DIAGNOSIS 3	151	156	6	Y	ICD Dx 3. If this is a non-hospitalization visit, it is the 3rd diagnosis entered.
APC CODE 3	157	159	3	Y	APC Recode for diagnosis 3
CAUSE OF DX 3	160	160	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 3
CAUSE OF INJURY	161	166	6	N	Valid ICD9 E code for an injury. If Diagnosis 3 is an injury 800-999.9.

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
PLACE OF INJURY	167	167	1	N	PCC place of injury code for Diagnosis 3 if Diagnosis 3 is an injury.
DIAGNOSIS 4	168	173	6	Y	ICD Dx 4. If this is a non-hospitalization visit, it is the 4th diagnosis entered.
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4
CAUSE OF DX 4	177	177	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 4
CAUSE OF INJURY	178	183	6	N	Valid ICD9 E code for an injury. If Diagnosis 4 is an injury 800-999.9.
PLACE OF INJURY	184	184	1	N	PCC place of injury code for Diagnosis 4 if Diagnosis 4 is an injury.
DIAGNOSIS 5	185	190	6	Y	ICD Dx 5. If this is a non-hospitalization visit, it is the 5th diagnosis entered.
APC CODE 5	191	193	3	Y	APC Recode for diagnosis 5
CAUSE OF DX 5	194	194	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 5
CAUSE OF INJURY	195	200	6	N	Valid ICD9 E code for an injury. If Diagnosis 5 is an injury 800-999.9.
PLACE OF INJURY	201	201	1	N	PCC place of injury code for Diagnosis 5 if Diagnosis 5 is an injury.
DIAGNOSIS 6	202	207	6	Y	ICD Dx 6. If this is a non-hospitalization visit, it is the 6th diagnosis entered.
APC CODE 6	208	210	3	Y	APC Recode for diagnosis 6
CAUSE OF DX 6	211	211	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 6
CAUSE OF INJURY	212	217	6	N	Valid ICD9 E code for an injury. If Diagnosis 6 is an injury 800-999.9.

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
PLACE OF INJURY	218	218	1	N	PCC place of injury code for Diagnosis 6 if Diagnosis 6 is an injury.
DIAGNOSIS 7	219	224	6	Y	ICD Dx 7. If this is a non-hospitalization visit, it is the 7th diagnosis entered.
APC CODE 7	225	227	3	Y	APC Recode for diagnosis 7
CAUSE OF DX 7	228	228	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 7
CAUSE OF INJURY 7	229	234	6	N	Valid ICD9 E code for an injury. If Diagnosis 7 is an injury 800-999.9.
PLACE OF INJURY 7	235	235	1	N	PCC place of injury code for Diagnosis 7 if Diagnosis 7 is an injury.

## Record 2 of 2

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
RECORD CODE 7	1	2	2	Y	00
SEQ #	3	3	1	Y	2
UNIQUE ID	4	19	16	Y	Use ASUFAC and HRN at location of encounter, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
ASUFAC-HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DIAGNOSIS 8	32	37	6	Y	ICD Dx 8. If this is a non-hospitalization visit, it is the 8th diagnosis entered.
APC CODE 8	38	40	3	Y	APC Recode for diagnosis 8

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
CAUSE OF DX 8	41	41	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 8
CAUSE OF INJURY	42	47	6	N	Valid ICD9 E code for an injury. If Diagnosis 8 is an injury 800-999.9.
PLACE OF INJURY	48	48	1	N	PCC place of injury code for Diagnosis 8 if Diagnosis 8 is an injury.
DIAGNOSIS 9	49	54	6	Y	ICD Dx 9. If this is a non-hospitalization visit, it is the 9th diagnosis entered.
APC CODE 9	55	57	3	Y	APC Recode for diagnosis 9
CAUSE OF DX 9	58	58	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 9
CAUSE OF INJURY	59	64	6	N	Valid ICD9 E code for an injury. If Diagnosis 9 is an injury 800-999.9.
ICD PROC CODE (1)	65	69	5	N	ICD Operation Code
PROC DATE (1)	70	76	7	N	Internal FileMan format of date of procedure.
INFECTION (1)	77	77	1	N	Y-Yes N-No
PROC PROV AFF/DISC(1)	78	80	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (1)	81	85	5	N	CPT Code for this Procedure
DX DONE FOR (1)	86	86	1	N	The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (2)	87	91	5	N	ICD Operation Code
PROC DATE (2)	92	98	7	N	Internal FileMan format of date of procedure.
INFECTION (2)	99	99	1	N	Y-Yes N-No
PROC PROV AFF/DISC(2)	100	102	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (2)	103	107	5	N	CPT Code for this Procedure
DX DONE FOR (2)	108	108	1	N	The number (1-9) of the diagnosis that this procedure was done for.

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
ICD PROC CODE (3)	109	113	5	N	ICD Operation Code
PROC DATE (3)	114	120	7	N	Internal FileMan format of date of procedure.
INFECTION (3)	121	121	1	N	Y-Yes N-No
PROC PROV AFF/DISC(3)	122	124	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (3)	125	129	5	N	CPT Code for this Procedure
DX DONE FOR (3)	130	130	1	N	The number (1-9) of the diagnosis that this procedure was done for.
IMMUNIZATION CODE	131	132	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	133	133	1	N	Set of codes
IMMUNIZATION CODE	134	135	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	136	136	1	N	Set of codes
IMMUNIZATION CODE	137	138	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	139	139	1	N	Set of codes
ADA CODE (1)	140	143	4	N	ADA CODE
ADA UNITS (1)	144	145	2	N	# OF UNITS
ADA CODE (2)	146	149	4	N	ADA CODE
ADA UNITS (2)	150	151	2	N	# OF UNITS
ADA CODE (3)	152	155	4	N	ADA CODE
ADA UNITS (3)	156	157	2	N	# OF UNITS
ADA CODE (4)	158	161	4	N	ADA CODE
ADA UNITS (4)	162	163	2	N	# OF UNITS
ADA CODE (5)	164	167	4	N	ADA CODE
ADA UNITS (5)	168	169	2	N	# OF UNITS
ADA CODE (6)	170	173	4	N	ADA CODE
ADA UNITS (6)	174	175	2	N	# OF UNITS
ADMISSION DATE	176	182	7	N	Admission date in internal FileMan format.
ADMISSION SERVICE	183	184	2	N	Admitting Service (2-digit IHS code)
ADMISSION TYPE	185	185	1	N	Admission Type
ATTENDING PHYSICIAN	186	191	6	N	Affiliation/Discipline code
CAUSE OF DEATH	192	197	6	N	ICD CODE

ITEM	BEG COL	END COL	LENGTH	REQ	DESCRIPTION OF DATA ITEM
# OF CONSULTS	198	200	3	N	Number of consults during an Inpatient Stay
DISCHARGE DATE	201	207	7	N	Internal FileMan Format of discharge date.
DISCHARGE SERVICE	208	209	2	N	From Standard Treating Specialty table
DISCHARGE TYPE	210	210	1	N	IHS Standard Code for Discharge Type
FACILITY TRANSFER TO (ASUFAC)	211	216	6	N	From Location table
LENGTH OF STAY	217	219	3	N	Length of Stay
MIDWIFERY	220	220	1	N	1 if midwife was a provider
ACTIVITY TIME	221	224	4	N	Minutes
TRAVEL TIME	225	228	4	N	Minutes
CHS COST	229	234	6	N	For CHS visits, total cost info.